BALTIMORE, MARYLANG	ed by the hos	uld be detache	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
E, MA	y be retaine	age 5 shou	be notific
MOR	Раде 6 та	director, p	er must
BALT	ter death.	the funeral	al examin
	nours af	filled in by	e medica
760	ed with	completely al, crematic	event, th
0X 68	be execut	ician and c	raumatic
.0.B	h certificate	Inding phys Hygiene pi	or other
RDS, I	at the deat	by the atte	y Injury.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	requires th	een signed of Health	shows an
ITAL	V: The law	State Dept.	Item 23
OFV	PHYSICIA	this certif	arked, or
ISION	NITENDING	STOR: After after deatl	28 Is ma
2	PITAL OR A	RAL DIRECT	C. If item
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANI

	FOR STATE REGISTRAR	STATE (	.mKYLAND C		RTMENT				MENTA	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)						•			E OF DEATH			3. TIME OF DEATH
	Frederick T	homas	FULK,	Sr.					May 31, 1995			YEAR	10:45 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER 1	YEAR	IF UNDE	R 24 HRS.		OF BIRTH	. , , ,		LACE (State or Foreign
1	213-03-1961	1 [X] M 2   F	83	YRS.	MONTHS	DAYS	HOURS	MIN.		th, Day, Year)	011	Country)	
1 8	9a. FACILITY NAME (If not institution, give a	atmet and number)	03		9b. CITY, T	OWN C	B LOCAT			27, 1		Mary	
00									AIN				
6	Garrett County Memorial Hospital					јак	1and				Ga	rrett	
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									T	IOd. INSIDE CITY		
H	MD Ga	rrett						0ak1	and				LIMITS?
	10e. STREET AND NUMBER					101	ZIP COD		arra		10a CII		IAT COUNTRY?
H/	215 Kendall Driv	0				-		2155	0		100	USA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDER	IT EVER IN IIS A	BMED	13 WH	S DEC	ENDENT			N? (Specify Ye	a an Na		
	1 Never Married 2 X Married	YES 2	NO	If y	es, sp	elfy Cubi	an, Maxica	n, Puerto	Rican, stc.)	e or No-		– American Indian, White, atc.	
BY	3 Widowed 4 Olvorced	WW I	MAR OR DATES		1 1	YES	2 ( <u>A</u> NO	Specify	/-			Specify	White
8	15. DECEDENT'S EDU		16a. D	ECEOENT'S	USUAL OCC	UPATIC	N .		16	b. KIND OF BU	SINESS/IN	DUSTRY	***************************************
<u> </u>	(Specify only highest grade Elementery/Secondery (0-12)		- fil	Give kind of	work done dui se retired )	ing mo	st of worki	ing				10.5.41	
급	8	Conege (1-4 of 5	Coal Mi				ente	r	N	lining/	Cons	truct	ion
COMPLET	17. FATHER'S NAME (First, Middle, Last)		000	113	1101700	11.0				Middle, Maiden		Cluce	1011
	Albert W.	Fulk,	Sr				-	lamie				ah1	
BE	19a. INFORMANT'S NAME (Type/Print)	ruik,		b MAII INC	ADDRESS (	Name of a				S .			
2	Mabel I. Fulk												F F O
	20g, METHOD OF DISPOSITION							, ua		d, Mar			550
	1 🔏 Buriel 2 🗆 Cremation 3 🗆 Rem	ioval from State	cemetery, cr	emetory or o	OF DISPOSITI				DA			City or Tow	
	4 Donetion 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIE	OFNICE	As	shby	Cemet				6/	3   0ε	ıklan	d, Ma	ryland
	11. SIGNAL OF FOREIGE ENVICE LI	A N						ESS OF FA		Homo			
	Stewart Funeral Home 32 S. Second St., Oakland, MD 21550												
	23. PART I. Enter the diseases, or	complications the	1 caused the d	eath. Do									Approximate
	snock, or heart failure. List only one cause on each line.								Onset and Death				
1 1	IMMEDIATE CAUSE (Final disease or condition	meta	static	nroct	ato C	A							1 year
1 1	resulting in desth)		OR AS A CONSI			Α							1 year
_			10111101101101	.ooc.roc o	. ,.								
CERTIFICATION	Sequentially list conditions,	b. DUE TO	(OR AS A CONSE	OUFNCE O	E)·								
A	If any, leading to immediate cause. Enter UNDERLYING		(011101101101		14.								i
유	CAUSE (Disease or Injury Co.												
E	that initiated eventa resulting in death) LAST		, , , , , , , , , , , , , , , , , , , ,		. ,.								İ
핑		d							-				
님	PART II. Other algnificant condition	na contributing to	death but not	reaulting	In the unde	rlylng	cause	given in	Part I.	24a. WAS AN			VERE AUTOPSY FINDINGS
MEDIC	Black_Lung									PERFOI			MAILABLE PRIOR TO COMPLETION OF CAUSE
	ВРН									1 1 163	XNO		OF DEATH?
	HBP								_				YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		-			26 PI	ACE OF I	DEATH (Che	ack only o	2001			
12	EXAMINER?  1 YES 2 X NO	HOSPITAL:	ED/O-1	. 🗆	OTHER:						_		
=	27. MANNER OF DEATH	28e. DATE OF		28b. TIN	4 Nursin			aaldence		er (Specify)	IN STREET OF	O IDEO	
	1 🕅 Natural 5 🗌 Pending		Pay, Year)		JURY	WO	JRY AT	7.00	28d. DE	SCHIBE HOW	INJURY OC	CURED	
B	2 Accident Investigation	20 21 102					'ES 2 [	NO					
ED	3 Suicide 8 Could not be	building.	OF INJURY — At h , etc. (Specify)	ome, farm,	atrest, fectory	, office			28f. LO	CATION (Street or Town, State)	and Numbe	r or Rural Ro	ute Number,
COMPLET	(Check only 1 X CERTIFYING PHYS												
OM	2 MEDICAL EXAMINE												and manner se stated.
U U	296. SIGNATURE AND TITLE OF CERTIFIE	A III					29c. LIC	ENSE NUN	IBER		29d DA1	E SIGNED /	Wonth, Oay, Year)
100		1						D153:			•		1/95
2	30. NAME AND ADDRESS OF PERSON WH	O COLLETED CALL	SE OF DEATH (IT	M 27) (Type	Deine)							0/	-175

311 N. Fourth Street, Oakland, Maryland
32. REGISTRAR'S SIGNATURE

Lin Division Revision

41VA

30. NAME AND ADDRESS OF PERSON WHO GO LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thomas Johnson, MD

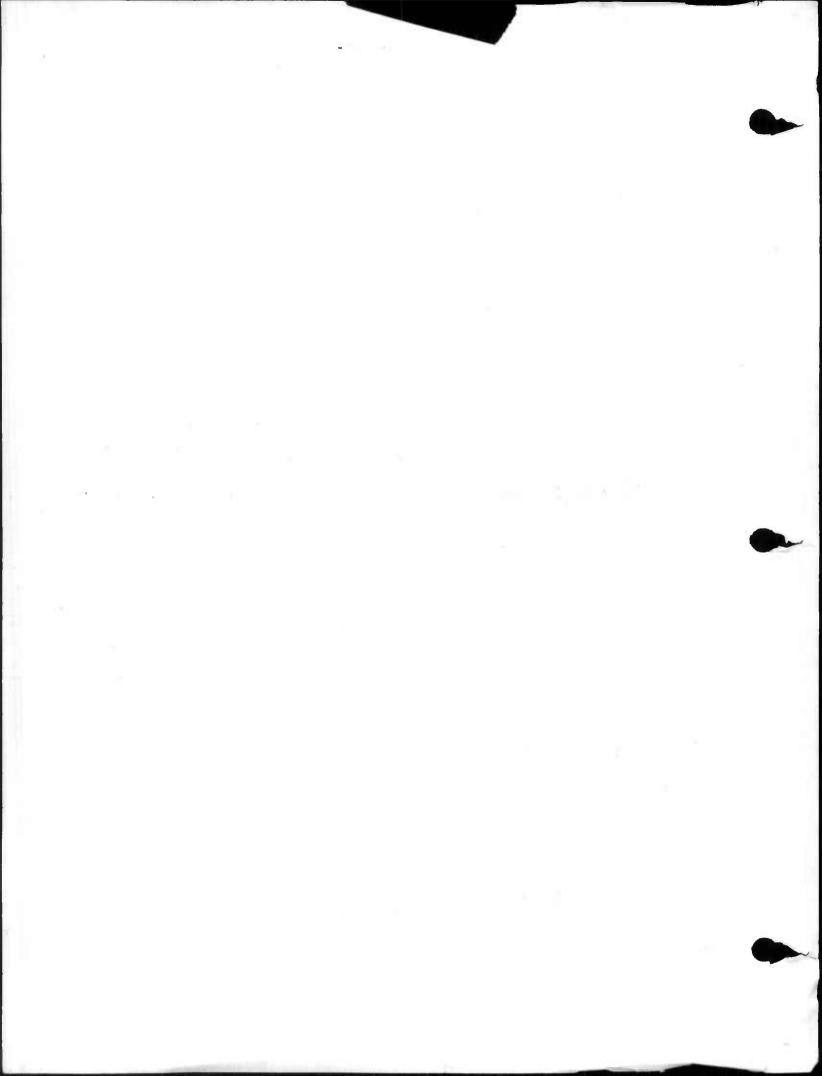
7 1995

31. DATE FILED (Month, Day, Year)

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	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	California Of Bearing						3. TIME OF DE	ATA:
1 4	JUNIOR ROBERT	- 1	2. DATE OF DEATH DATE OF MAY 28	-	YEAR				
	4. SOCIAL SECURITY NUMBER		(in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or	
	217-30-1575	1 💢 M 2 🗌 F	61 YRS.	MONTHS DAYS	HOURS MIN.	Oct. 17,	1933 N	Country) Maryland	
	Sa. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF DEA			Y OF DEATH	
DIRECTOR	SACRED HEART H	OSPITAL		CUMBE	ERLAND		ALLE	GANY	
S S	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	TY	10c. Cl	TY, TOWN OR LOC	ATION			10d. INSIDE CI	TY
5	MD	Garrett		(	0akland			LIMITS?	XNO
AL	10e. STREET AND NUMBER			1	Of. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY	
FUNERAL	6803 Oakland-Sar	ng Run Road			21550		Į	JSA	
5	11. MARITAL STATUS 1 Never Merried 2 X Married	12. WAS OECEDENT EVER FORCES? 1 XYES	IN U.S. ARMED		CENOENT OF NISPANIC		or No- 14	I. RACE — American Inc Black, Whits, etc.	dian,
	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	DATES		S 2 X NO Specify:	, , ,	1	Specify:	
	15. OECEDENT'S EOL	CATION	16a. DECEDENT'S	S USUAL OCCUPAT	TION	18b. KIND OF BUS	I SINESS/INDUS	Whit	Le
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give kind of life. Do NOT u	work done during n use retired.)					
COMPLETED		2		Inspec	tor	States	Highwa	ay Adminis	trat
5	17. FATHER'S NAME (First, Middle, Last)		"		16. MOTHER'S NAME	E (First, Middle, Melden	Surname)		
1	Alvin Harris	Theresa	Elle	n	Teets				
2	19s. INFORMANT'S NAME (Type/Print)				end Number or Rural Ro			,	
	W. Marie Friend				-Sang Run				
	20a METNOD OF DISPOSITION 1 (3) Burlat 2 Cremation 3 Rem	novel from State Ce	b. PLACE AND OATE		Gardens			y or Town, Stets	
	4 Donation 5 Other (Specify)		Garrett		Gardens		Land,	Maryland	
	D. M. a	11.1			wart Funer				
	32 S. Second St., Oakland, MD 21550								
1	23. PART I. Enter the diseases, or shock, or heart failure.	complications that cause List only one cause on (	d the death. Do	not enter the m	ode of dying, such	aa cardiac or reapi	ratory arres	it, Approxim	
ł	iMMEDIATE CAUSE (Finei disease or condition	a 417	/	2 00 100				Onset s	rd Deat
ł	resulting in death)	BUE TO JOH AS	A CONSEQUENCE O	demi				2/2	m
	_	Sona	1 Fai	"ly re				15	n
)	Sequentially list conditions, if any, leading to immediate								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or injury	· Myelo	tibn	05°, S.	-				
	thet initiated events	DUE/TO (OR AS	A CONSEQUENCE C	OF):					
Ú	resulting in death) LAST	6							
	PART II. Other significant condition	ns contributing to death	but not resulting	in the underlyi	ng cause given in Pi	ert I. 24a. WAS AN		24b. WERE AUTOPSY	FINDING
= 1						PERFOR		AMILABLE PRIO	
	A .					_	A) NO	DF DEATH?	NO
1		ES NO [	UNCERTAIN						
The state of the s	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNC  25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)						
מאווי ווורסוסטו	25. WAS CASE REFERRED TO MEDICAL				9)				
COLORIA: MICOLORIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPIFAL:	26. PLACE OF DEA	OTHER:	me 5 Residence 6	Other (Specify)			
THI SICIAN. MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	HOSPITAL:	26. PLACE OF DEA	OTHER: 4 Nursing No ME OF 28c. IN JURY	me 5 Rasidencs 6	Other (Specify)	NJURY OCCUP	RED	
PHISICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNEB OP DEATH  1 Netural 5 Pending Investigation	HOSPIFAL: 11 Inpetient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Year)	26. PLACE OF DE/ patient 3 DOA 28b. Til	OTHER: 4 Nursing No ME OF JURY M 1	me 5 Residence 6  JURY AT /ORK?  YES 2 NO	ted. DESCRIBE HOW I			
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNED OP DEATH  1 Netural 5 Pending	HOSPITAL: 11 Impetiant 2 ER/Out 28s. DATE OF INJURY (Month, Dey, Year)	26. PLACE OF DEA	OTHER: 4 Nursing No ME OF JURY M 1	me 5 Residence 6  JURY AT /ORK?  YES 2 NO				
D DT PRISICIANS	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNEB OP DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined	HOSPIFAL: 11 Inpatient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Year) 28s. PLACE OF INJUR building, etc. (Spe	28. PLACE OF DEJ patient 3 DOA 28b. Til iN Y — At home, term,	OTHER:  4   Nursing No ME OF JURY M 1    atreet, factory, off	Me 5 Residence 6  UJURY AT  ORK?  YES 2 NO  ica 2	18t. LOCATION (Street of City or Town, State)	and Number or	Rural Route Number,	
D BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNEB OP DEATH  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined  29a. CERTIFIER (Check only)	HOSPIFAL:  11 Tripettent 2 ER/Out  28s. DATE OF INJURY (Month, Dey, Year)  28s. PLACE OF INJURY building, etc. (Spe	28. PLACE OF DE/ patient 3 DOA 28b. TII iN Y — Al home, tarm, cify)	4 Nursing No ME OF JURY M 1 atreet, factory, off	HIDERY AT CONTROL OF THE PROPERTY AT CONTROL OF	tel. DESCRIBE HOW II  tel. LOCATION (Street of City or Town, State)  the cause(s) and man	and Number or	Rural Route Number,	
COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNEB OP DEATH  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined  29a. CERTIFIER (Check only)	HOSPIFAL:  1(i) Inpetient 2 = ER/Out  28s. DATE OF INJURY (Month, Dey, Year)  28s. PLACE OF INJURY building, etc. (Spe	28. PLACE OF DE/ patient 3 DOA 28b. TII iN Y — Al home, tarm, cify)	4 Nursing No ME OF JURY M 1 atreet, factory, off	HIDERY AT CONTROL OF THE PROPERTY AT CONTROL OF	tel. DESCRIBE HOW II  tel. LOCATION (Street of City or Town, State)  the cause(s) and man	and Number or	Rural Route Number,	stated,

924 SETON DRIVE CUMBERLAND, MD.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

32. REGISTRAR'S SIGNATURE

URIEL,

VELANDIA,

31. DATE FILED (Month, Day, Year)
JUN 6

DHMH-16 Rev 1/89

21502

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)
MAY 31 1995

32. REGISTRAR'S SIGNATURE

A	mended 105	5/2/	~/ -	m D		0	1. 1.			9	5	185	03
	mended /05  1 - FOR REGISTRAR	STATE OF MA	RYLAND /	DEPAR ERTIF	/ TMENT ICATE	OF I	HEALTH AND	MENT	AL HYGIEN	IE Ou	nT	7.	
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DAT	E OF OEATH	AY	YEAR	3. TIME OF	DEATH
	Lawren 4, Social Security Number	ce Franci						May	27, 1	995		4:45	Ам
	129-03-0473	5. SEX 6	AGE (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS MIN.	(Mo	E OF BIRTH	1000	Countr		or Foreign
	9a. FACILITY NAME (If not institution, give s		92	THO.	9b, CITY	TOWN (	OR LOCATION OF D		. 25,		TU NTY OF D	rkey	
DIRECTOR	Medlantic Manor a	t Layhill					spring				tgon		
IRE	Maryland Monto				Y, TOWN O							10d. INSIDE	CITY
	100. STREET AND NUMBER	jomery		51	lver	<del></del>	ring					1 YES	. /
FUNERAL	1129 Spotswood Dr	rivo				100	20904 <i>2</i>	00	1	-		CHAT COUNT	
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARI	MED	13. V	NAS DEC	CENOENT OF HISPAI	NIC ORIG	IN7 (Specify Yes			State - American	
BY F	1 Never Married 2 Married  3 Widowed 4 Divorced	FORCES? 1	YES 2 X N OR DATES	10	81	f yea, ap	ecify Cuban, Mexica 2 X NO Specif	in, Puerto	Ricen, etc.)		Black Speci		
ED B	TAX	CATION										ite	
ETE	(Specify only highest grade completed)				USUAL OC vork done d to retired.)	CUPATION INC.	ON ost of working	10	ib. KIND OF BU	SINESS/IND	USTRY		
APL.	12	College (1-4 or 5+)		Usic					Self-e	emplo	ved		
COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First,			, ou		
BE	Francis Gunn						Alice		lizabet			in	
2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  JOSEPH Lee Lacy  1116 Spotswood Drive, Silver Spring, MD 20905												
	Joseph Lee Lacy   1116 Spotswood Drive, Silver Spring, MD 20905  20a. METHOD of DISPOSITION 1   Burlel 2   Cremation 3   Removal from State 4   Donation 6   Other (Specify)   Chesapeake Crematory    20b. PLACE AND DATE of DISPOSITION (Name of Cemetery, cremetery or other place)    Chesapeake Crematory   5-28   Beltsville, Maryland												
	1 Buriel 2 N Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from State	cemetery, cree Ches	netory or of	ther place) ke Ci	rema	atorv	5-	28 Re 1+	svil	le l	wn, state Mary la	and
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								arra				
	> Ellen	J. Ka	PP		93	3 G:	ist Avenu	Je.	Silver	Spri	na.	MD 20	910
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
	IMMEDIATE CAUSE (Fine)								Onset	and Death			
	resulting in death)	a. Coronary	Y APTER			е							Years
z		b.			,-								
TIFICATION	Sequentially list conditions, if any, leading to immediate  DUE TO (DR AS A CONSEQUENCE OF):												
	couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated exercises DUE TO (OR AS A CONSEQUENCE OF):												
	that initieted events resulting in death) LAST	·	I AS A CONSEC	OENCE OF	,.								
CE		d										_	
MEDICAL	PART II. Other algoriticant condition  Dementia	a contributing to de	eth but not re	esulting I	n the und	derlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOP	RIOR TO
ED	Dementina								1 TYES 2	NO X		OF DEATH?	OF CAUSE
Σ.	DID TOBACCO USE CONTI	RIBUTE TO CAU'	SE OF DEAT	TH YE	SIL	10 F	UNCERTAIN					1 YES 2	Ои)Х⊓
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIDOTE TO CAO.			H (Check o			<u>ч                                    </u>					
/SIC	EXAMINER?	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER 4X Nurs		e 5 Residence	6 Oth	er (Specify)				
PH	27. MANNER OF DEATH XX Natural 5 Pending	26a. DATE OF IN. (Month, Day,		26b. TIMI	E OF URY	26c. INJ WO	URY AT	28d. DE	SCRIBE HOW I	NJURY OCC	URED		
ВҰ	2 Accident Investigation	200 84 405 05 4	A MIRROR		М		YES 2 NO						
ED	3 Suicide 6 Could not be determined	28e. PLACE OF II building, etc	. (Specify)	ne, term, s	treet, lecto	ry, offic	•		CATION (Street a y or Town, State)		or Rural A	oute Number,	
J.E.	29a. CERTIFIER (Check only 1 ) CERTIFYING PHYSI	CIAN: To the best of m	knowledge des	th occurre	d at the tie	no dete	and place and dui	4 a Tabilita					
COMPLETED		R: On the basis of exam										and manner	as stated.
	296. SIGNATURE AND TITLE OF CENTIFIE						29c. LICENSE NUM					(Month, Day, 1	
O BE	1 april acid	MD					D 32417					, 199	
5	30. HAME AND ADDRESS OF PERSON WH										-		
	Rabul Gilotra, M.	n. 1201	6 Georg	nia /	AVENI	10	Wheaton	MD	20902				

Later Line Line

45 :15

Maryland

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify: White

9c. COUNTY OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

REG. NO

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

31. DATE FILED (Month, Day, Year)

31 1995

1. DECEDENT'S NAME (First, Middle, Last)

68760
BOX
S, P.O
ECORD
ITAL B
NOF
DIVISIO

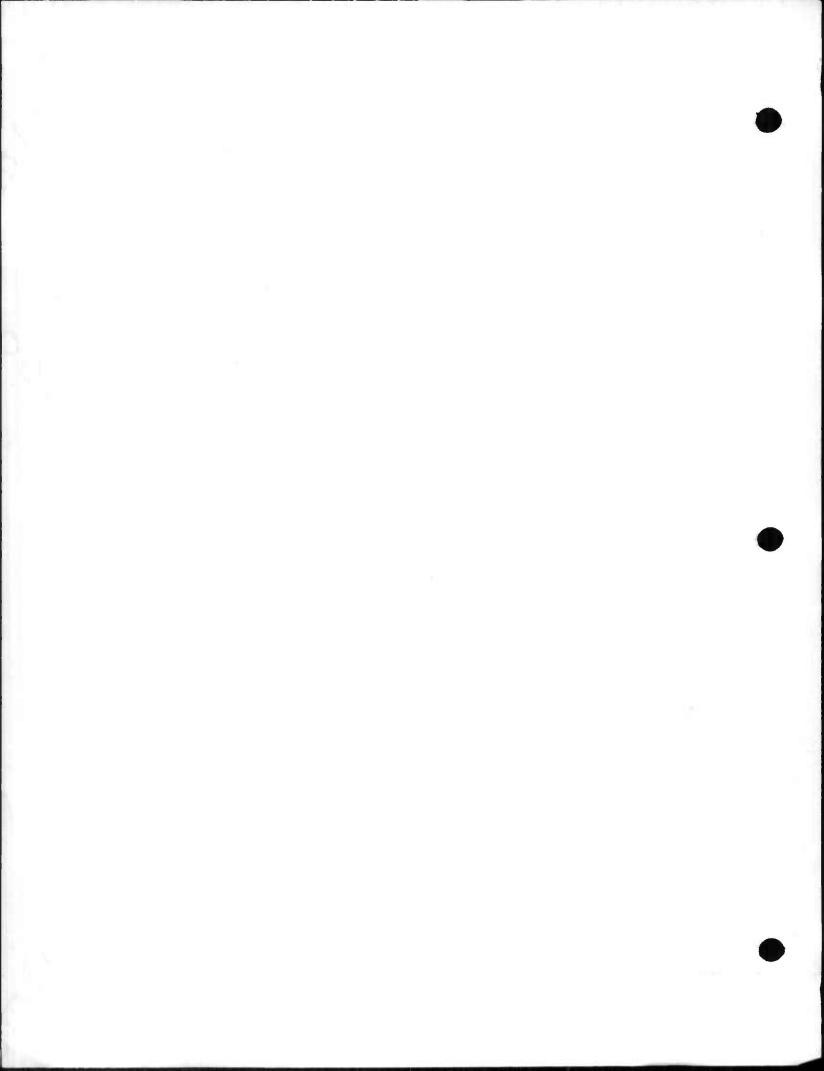
Nez RAh GERACI 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) 7. DATE OF BUITH (Month, Dec. West IF UNDER 1 YEAR | IF UNDER 24 HRS DAYS HOURS BRIN 1 🗌 M 2 🔜 F 578-10-4667 YRS 84 May 9, 1911 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Holy Cross Hospital Silver Spring RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit. 13104 Serpentine Way 20904 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS If yes, specify Cuban, Maxican, Pr 1 YES 2 NO Specify: 1 Never Married 2 Married BY 3- Widowed 4 ☐ Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Accounting Clerk Furniture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To John Frederick Hamilton Mary Elizabeth Case BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charlene L. May 13104 Serpentine Way Silver Spring, Maryland 20904 pe 20e. METHOD OF DISPOSITION
11/2 Burtisl 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Must 10 Colesville Cemetery ☐ Donation 5 ☐ Other (Specify) 5/31/95 Colesville, Maryland 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis J. Collins Funeral Home, Inc. examiner death. amsey 500 University Blvd., W. Sil. Spr., MD 20901 hours after medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. **IMMEDIATE CAUSE (Fine)** the disease or condition event, reculting in death) executed Obstruch traumatic CERTIFICATION Sequentielly list conditions, TO JOR AS A CONSEQUENCE OF Hygiene prior to been signed by the attending physician of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 0 PART iI. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO requires Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN The law PHYSICIAN: DIRECTOR: After this certificate has b hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY marked, 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural м 1 YES 2 NO Investigation BY 2 Accident 28s. PLACE OF INJURY — Al home, farm, street, factory, offica building, atc. (Specify) 60 3 Suicide 8 Could not be COMPLETED 4 Homicide 28 29a. CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
be filed within 7. 296. SIGNATURE AND TITLE OF CERTIFIER B 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print, 4701 Rockur Randolph

REGISTRAR'S SIGNATURE

alia Davides Rent

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> Approximate **Onset and Death** days 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) DHMH-16 Rev 1/89



ital or attending physician. I for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

irs after death. Page 6 may be retained by the hospit	n by the funeral director, page 5 should be detached	removaí.	edical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence.	

	1 - STATE STATE REGISTRAR	E OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)	0	1	2. DATE OF DEATH	3. TIME OF DEATH					
	D. Earle	Gr	xham	MONTH 27 1	995 1235 PM					
	4. SOCIAL SECURITY NUMBER 5. SEX		UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)					
	011110140	074-14-6463   1XM2   19 YAS.   12-29-1915 NE								
æ	9a. FACILITY NAME (If not institution, give street and n	9a. FACILITY NAME (if not institution, give atreet and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH								
5	WASHINGTON ADVEN	TIST HOSPITAL I	AKOMA PAI	CK /	10NTGOMERY					
DIRECTOR	MARYLAND PRINCE GEORGE'S GREENBELT									
	100. STREET AND NUMBER									
FUNERAL	2-A WOODLAND	WAY	G. CITIZEN OF WHAT COUNTRY?							
Ž	11. MARITAL STATUS 12. WAS	DECEDENT EVER IN U.S. ARMED	2077	NIC ORIGIN? (Specify Yes or No	- 14. RACE - American Indian.					
BY F		CES? 1 TYES 2 NO ES, GIVE WAR OR DATES	If yes, specify Cuban, Mexico	n, Puarlo Rican, etc.) y:	Specify: WHITE					
ED E	15. DECEDENT'S EDUCATION	16e. DECEDENT'S USI	IAL OCCUPATION	16b. KIND OF BUSINESS						
ETE	(Specify only highest grade completed,	(Give kind of work life. Do NOT use re	done during most of working		K STATE					
APL	10	2 ACCOUN	THAT	1						
COMPLET	17. FATHER'S NAME (First, Middle, Last)	0 2 4	16. MOTHER'S NA	ME (First, Middle, Maiden Surnan						
BE	STANLEY	GRAHAM	IDA		NTROSS					
2	190. INFORMANT'S NAME (TYPE/PYINI) MARGARET A. GR		ORESS (Street and Number or Rural	Route Number, City or Town, State	i, Zip Code)					
	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF D	ISPOSITION (Name of	DATE 20c. LOCATION	N — City or Town, Sieta					
	1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State cemetery, crematory or other	PA C REMATERY S	-29-95 ALEXA	NORIA, VIRGINIA					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  4400 POWPER MILL Rd.									
	Warld V, Box	Naula VID orgivarel. BELTSUILLE Md. 20705								
	23. PART I. Enter the diseases, or compiler shock, or heart failure. List only	lions that ceused the deeth. Do not	enter the mode of dying, suc	h és cerdiec or reepiratory	arreat, Approximate					
	IMMEDIATE CAUSE (Final	ACALL CALL VI	11 total 1 A		Onset and Death					
	disease or condition resulting in death)  a. DUE TO (DRIAS A CONSEDUENCE OF):									
7		A CONSEDUENCE OF):			Ų					
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A CONSEDUENCE OF):								
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	cause. Enter UNDERLYING								
TIF	that initiated events resulting in death) LAST	Initiated events DUE TO (OR AS A CONSEQUENCE OF):								
CEF	d	d								
AL	PART, II. Other significant conditions contrib	uting to death but not resulting in the	ne underlying cause given	Part I. 24s. WAS AN AUTOF PERFORMED?	PSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
MEDIC	THE MANAGE	MANAGERA	VAI OF	1 YES 2 DM	COMPLETION OF CAUSE OF DEATH?					
Σ	DID TOBACCO USE CONTRIBUTE	TO CAUSE ON DEATH YES	NO □ UNCERTAI	1.00	1 🗆 YES 2 🗆 NO					
IAN	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (C		NET						
SIC	1 YES 2 NO 1 No 1		HER: Nursing Home 5 Residence	6 C Other (Specify)						
PHYSICIAN:	_/	DATE OF INJURY 286. TIME OF (Ministry, Clay, West) INJURY	38c. INJURY AT WORK?	284. DESCRIBE HOW INJURY	OCCURED					
ВУ	1 Natural 5 Pending 2 Accident Investigation		M 1 YES 2 NO							
ED	3 Suicide 6 Could not be 4 Homicide determined	PLACE OF INJURY — At home, term, stree building, etc. (Specify)	t, factory, office	281. LOCATION (Street and Nur City or Ewen, State)	nber or Rurel Route Number.					
COMPLETED	290. PUFIER 1 CERTIFYING PHYSICIAN: TO I	he heat of my knowledge, death economic		20 - 1100						
MP		he best of my knowledge, death occurred at beals of stemination and/or investigation, in								
	The BIOM TURE AND TITLE OF CHITCHEN	Alla	29c. LICENSE NUI		DATE SIGNED (Month, Day, Year)					
O BE	The Ull	(MVVM)	111 1061	499	my 17, 1995					
٩	30. NAME AND ADDRESS OF PERSON WHO COMPLE	TED CAUSE OF DEATH (ITEM 27) (Type, Prin	0							
	31. DATE FILED (Month, Day, Year)	DEGISTDADE SIGNATURE								
	MAY 30 1995	REGISTRAN'S SIGNATURE DRUMBLEN NAMBELL								

ning managarang dilikat na angada na dilikat

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netitled at once.

								9	0	18200
	1 - FOR STATE REGISTRAR	STATE OF MARY			HEALTH AN		TAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. D.	ATE OF DEATH			. TIME OF DEATH
	CLIFFORD	Τ.	GRAY	JR.			AY 26,		YEAR	18:16 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 H	IRS 7 D	ATE OF BIRTH			LACE (State or Foreign
	219-38-6052	15XM2□F 56	YRS.	MONTHS DAYS	HOURS M	···· MA	RCH 1,19	939	MARY	
	9e. FACILITY NAME (If not institution, give a			9b. CITY, TOW	OR LOCATION (				NTY OF DEA	TH
H H	SINAT HOSPITA	LER		דגם	TIMORE			BA	LTIMO	RF
DIRECTOR	SINAI HOSPITA			DAL.	TMOKE					
H	10a. STATE 10b. COUNT		10c, CIT	Y, TOWN OR LOC					10	0d. INSIDE CITY LIMITS?
		E GEORGES		BOV	IE				1	YES 2 NO
\¥	10e. STREET AND NUMBER				IOF. ZIP CODE					AT COUNTRY?
Ü	P.O. BOX 1036	RACE TRACK	ROAD		20715			UNI	TED S	TATES
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS D	ECENDENT OF HI	ISPANIC OR	IGIN? (Specify Yes	or No-	14. RACE -	- American Indian, White, atc.
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		ES 2 NO S		rto riican, atc.)			WHITE
		1958								WILLIE
	15. DECEDENT'S EDU (Specify only highest grade	completed)	16e. DECEDENT'S	work done during	TION most of working		16b. KIND OF BUS	SINESS/IND	USTRY	
1	Elementary/Secondary (0-12)	College (1-4 or 5 +)	HODGE	TRAINEF	)	ı	THOROUG	HDDE	D DAC	TNC
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0	HONSE	TRAINER					D KAC	TNG
		RAY SR.					st, Middle, Meiden GINIA S	SUMEMO) SHOEM	VKED	
H	19e. INFORMANT'S NAME (Type/Print)	MI 31/.								
2	TAMMY L. LUMSDEN		2042	TIII LIAT	ER ROAL	Runal Route N	tumber, City or Town			1784
	29 METHOD OF DISPOSITION		Db. PLACE AND DATE							
	1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		LAY TUNSVI			5/31			VIII F	, State , MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC		4							SHARTEAND
	> muriel	1. (Da	her,				FUNERAL			0882
Н		47.10					YTONSVIL			AND
	23. PART i. Enter the disesses, or eshock, or heart failure.	complications that cause. List only one cause on	ed the deeth. Do reach ilna.	not enter the n	node of dying,	such ss c	esrdiac or respi	ratory arm	est,	Approximats Interval Between
1 1	IMMEDIATE CAUSE (Fine) disease or condition	11.	.1 1	1			0-			Onset and Death
	resulting in death)	· Marins	Motor	- Caro	Wrs	scul	inju	Coes	r8	,
		3 DOE TO JOR-AS	CONSEQUENCE	P: h	100	21		-		
RTIFICATION	Sequentisity list conditions,	b. DUE TO (OR VIS	A CONSEQUENCE OF	24	che	507	ma	~~ (C	>	
FA	If sny, leading to immediate cause. Enter UNDERLYING	50E 10 (011 <b>\$</b> 0	A CONSECUENCE OF	,	'		$\circ$			
[윤]	CAUSE (Disesse or injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF	T:						
E	resulting in death) LAST									İ
핑		0.								
AL	PART II. Other significant condition	s contributing to death	but not resulting	n tha underly	ng cause give	n in Part i	. 24a. WAS AN			ERE AUTOPSY FINDINGS
EDICAL			<del></del>				1 YES 2		CC	OMPLETION OF CAUSE F DEATH?
ME							1 "		1,	YES 2 NO
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YE	S I NO	UNCER	TAIN 🗆			/	
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	1100001711	26. PLACE OF DEAT		)					
S	1 VES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐XER/Ou	tpetient 3 DOA	OTHER: 4 Nursing He	me 5 🗆 Reside	nce 6 🗆 0	ther (Specify)			
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d.	OESCRIBE HOW IN	VURY OCC	URED	0
BY	1 Netural 5 Pending 2 Accident Investigation	May 26.	1995 175	- N . No	YES 2 NO	. 8	ewer	OF F	1 CK	noth cues
	3 Suicide 6 Could not be	26e. PLACE OF INJUF building, etc. (Sp	ty — At home, term, sectly)	treet, fectory, of	Ice	26f. L	OCATION (Street a	nd Number	or Rural Roul	
ETE	4 Homicide determined		STR	SET		3	so Ble	MM	GM.	thery
17	290. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my kno	wiedge, death occurre	d at the time, da	te end place, and	due to the	cause(e) and men	nor as state	ed.	
COMPL		R: On the beele of examinati								nd menner se stated.
Ü	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE					Ionth, Day, Year)
( CO	1	× .								
유	30. HAME AND ADDRESS OF PERSON WAS	O COMPLETED CAUSE OF D	PATH OTEM AT CO.	25-11	J OCM	1E	MAY 27,			1,1995

O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

PENN

STREET BALTIMORE, MARYLAND

32. REGISTRAR'S SIGNATURE
WALLOW RENDELL

MAY 30 1995

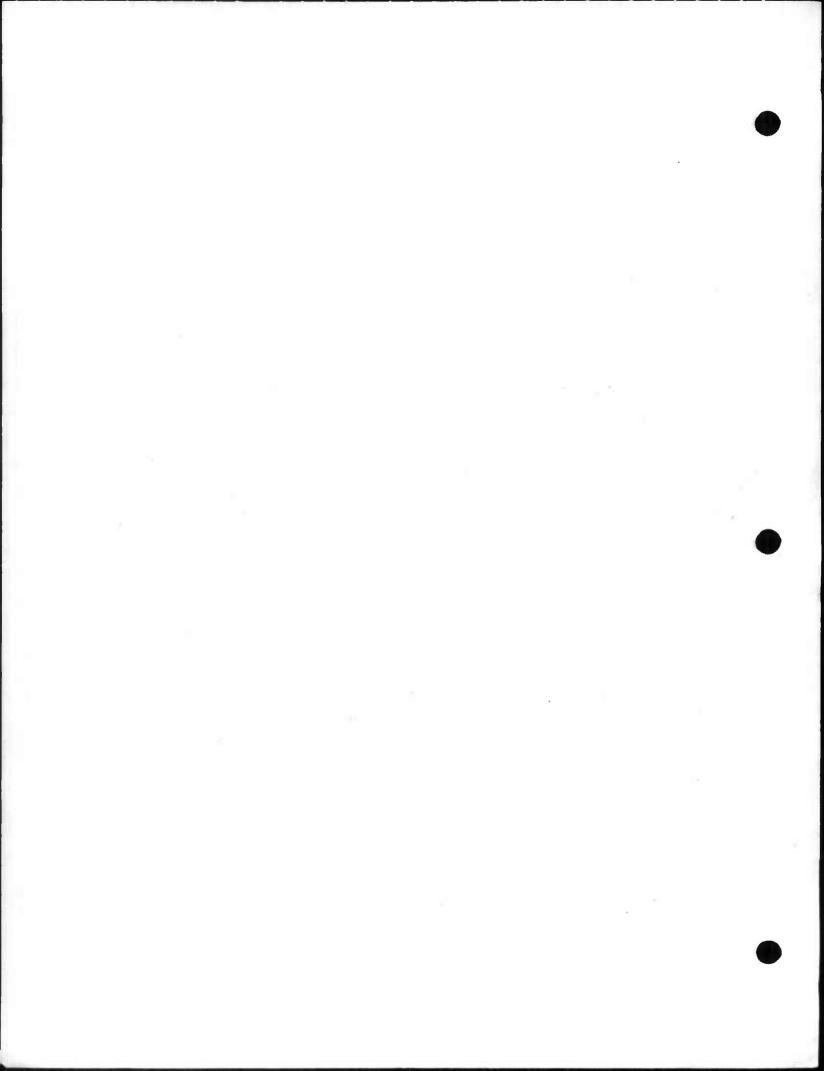
DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	ENT OF HEALTH AN	D MENT	AL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)			E OF DEATH	_	3. TIME	OF DEATH			
	Jennie	Ga1	.eano		Ма		995	EAR 1	1:58	Рм
	10.1	5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF					ATE OF BIRTH 8. BH			
	1	95 YAS.				y 5, 18		country)		
_	9a. FACILITY NAME (If not institution, give street	F DEATH		9c. COUNTY	OF DEATH					
DIRECTOR	Washington Adventi	st Hospital	Т.	akoma Park			Monte	omery		-
HE(	10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION					SIDE CITY	
		gomery		Silver Sprin	g			ES 2 N	0	
M	10e. STREET AND NUMBER			10f. ZIP CODE			10g. CITIZEN	OF WHAT CO	UNTRY?	
FUNERAL	1318 Stateside Dri			2090				USA		
	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYES	2 NO	13. WAS DECENDENT OF HIS It yes, specify Cuben, Ma	SPANIC ORIG	IN? (Specify Yes Rican, atc.)	or No— 14.	RACE - Ame Black, White,	rican Indian, atc.	
B	3 🖾 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DA	ATES	1 TYES 2 THO SE	ecity:			Specify:		
G	15. DECEDENT'S EDUCA	FION	16a. DECEDENT'S USUA	AL OCCUPATION	16	b. KIND OF BUS	INESS/INDUST	White		
H.	(Specify only highest grade co	College (1-4 or 8 +)	(Give kind of work of ille. Do NOT use retir	one during most of working ed.)			noetane da			
AP.	6		Seamstre	SS		Clothi	ng			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S	NAME (First,	Middle, Malden S	-			
BE	Louis Lozupone			Celes	ste Fr	reda				
0	19a, INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Ru				-/		
-	Catherine G. Amber	g	1318 Sta	ateside Drive	e Sil	Lver Sp	ring,M	arylan	d 209	003
	20a. METHOD OF DISPOSITION  1 Surial 2 Cremation 3 Remove	al from State 20b.	PLACE AND DATE OF DIS	POSITION (Name of ace)	5/30/4	20c. LOC		or Town, State		
	4 Donation 6 Other(Specify)	Ar.	lington Nat	col Cional Cemete	ery	Ar1:	ington	,Virgi	nia	
	Francis J. Collins Funeral Home, Inc.									
	Mara di	1/we	lla !	00 Universit	tv Blv	7d. W. S	Sil.Sp	r. MD		
	23. PART I Enter the diseases, or cor shock, or heart failure. Lis	nplications that caused it only one cause on er	the deeth. Do not each line.	nter the mods of dying,	such as ca	rdisc or respir	atory arrest		pproximate terval Betv	
	IMMEDIATE CAUSE (Finel disease or condition	ſ., , A.O			r. c. c		1 -	nset and D	path	
	resulting in desth) s.	SMULAX	WLAK MOMEDIUIC				1 5	116	100	
	IMMEDIATE CAUSE (Fine)  disease or condition resulting in death)  Sequentially list conditions  a. ITYPERO SMULAR MONKETUTIC COMA  Due to (or as a consequence of):  ADVANUED  ADVANUED  ADVANUED  ACCES  DESCRIPTION OF THE CONDITIONS  ADVANUED  ACCES  ADVANUED  ACCES  DESCRIPTION OF THE CONDITIONS  ADVANUED  ACCES  DESCRIPTION OF THE CONDITIONS  DESCRIPTION OF THE CONDITIONS  ACCES  DESCRIPTION OF THE CONDITIONS  DESCRIPTION OF THE CONDITIONS  ACCES  DESCRIPTION OF THE CONDITIONS  ACCE									
ON I	order week and the conditions,	OUE TO (OR AS A	CONSEQUENCE OF:	110		1				
AT	If sny, leading to immediate cause. Enter UNDERLYING	SEP	514					In	M	
CERTIFICATION	CAUSE (Disease or injury that initiated events		CONSEQUENCE OF):							
EH	resulting in death) LAST									
	PART II. Other significant conditions	contributing to death by	it not regulting in the	. underhalen eines eines	In Part I	24a, WAS AN A			200	
SAL	ATRIAL	FIR ALL	ATIZZI	underlying cease given	IN PHILL.	PERFORM	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
	VENTOIN	21 10 -	TACH	1 CARNILA		1 TES 2	NO	OF DEAT	H7	
Σ	DID TOBACCO USE CONTRII	RUTE TO CAUSE O	F DEATH YES	NO □ UNCERT	ľ		1 🗌 YE	8 2 NO		
NA I	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH (Ch		AIIV M					$\dashv$
PHYSICIAN: MEDIC		IOSPITAL:		HER: Nursing Home 5 - Residen	ce 6 Cth	er (Snecify)				
둦	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT	7	SCRIBE HOW IN	JURY OCCUR	ED		$\dashv$
ВУ	1 Natural 5 Pending 2 Accident Investigation	(MONUN, Day, IDEI)	INJUNT	WORK?						ł
ED	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, street,	tactory, office	281. LO	CATION (Street any or Town, State)	nd Number or F	tural Route Nurr	nber;	
# 1	4 Homicide determined				J.,	or ionii, orale)				
	Check only CERTIFYING PHYSICIA	N: To the best of my knowle	edge, death occurred at t	he time, date and place, and	dua to the ca	ouse(a) and mann	ner as stated.			
COMPLET	one) 2 MEDICAL EXAMINER:	On the basis of examination	end/or investigation, in	my opinion, death occured at	the time, dat	a and place, and	due to the ce	use(a) and ma	nner aa stati	ed.
BEC	29b. SIANATURE AND TITLE OF CERTIFIER		^ ^ >	29c. LICENSE	NUMBER ,	,	29d. DATE SI	GNED (Month, L	Day, Year)	-1
0	Arcil M.	nelve	. /~/	1973	736	6	D 51	24/0	15	
F	30. NAME AND ADDRESS OF PERSON WHO		TH (ITEM 27) (Type, Print)	11:			wile	Del	6	
	21	NE HTA -		ultimore 1	ve a	1 504	VY VO	2 / 3	OFL	10
	MAY 30 1995	JE REGISTRAR'S SIONA	TUBE III				- 6			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici

DIVISION OF VITAL RECO

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CERTIFICATION

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item

DIRECTOR: , 50

TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If II

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE 1 -REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH May 27, 1995 Derek Fred Goerg 3:10 A. 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Feb. 20, DAYS 1 X M 2 | F 220-84-0293 33 YRS. 1962 Alaska 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF OEATH 7732 Dew Wood Drive Derwood Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Derwood 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE 7732 Dew Wood Drive 20855 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 X Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 3 Wildowed 4 Divorced White 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (GIVe kind of work done life. Do NOT use retired ) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Roman Catholic Priest Archdiocese of Washington 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Frederick Clarence Goerg Marilyn Joyce Voit 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick C. Goerg 7732 Dew Wood Drive, Derwood, Maryland 20855 20e\_METNOD OF DISPOSITION
1 (ABurlel 2 Cremetlon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 5/31 Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 23. PART I. Enter the desease or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiretory arrest, shock, or heart fallura. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition Hepatic Failure resulting in dasth) 1 Month DUE TO (OR AS A CONSEQUENCE OF): Hepatic Metastases 1 Year Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If sny, lasding to immediate csuse. Enter UNDERLYING Metastatic Rectal Cancer 1 Year CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to desth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS

Renal Failure Hepatic Encephalopathy

1 TYES 2 X NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 NES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 
NO 
UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) OTHER: 1 TES 2 X NO 1 | Inputient 2 | ER/Outputient 3 | DOA 4 Nursing Nome 5 X Residence 6 Other (Specify)

27 MANNER OF GEATN 1 X Netural 5 Pending

2 Accident 3 Sulcide 6 Could not be 4 Nomicide determined

28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF M 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)

uro>

28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 🗶 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, desth occured at the time, data and place, and due to the cause(s) and manner as stated. 296. WOMATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D24994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

2

Mark Birns, M.D., 9711 Medical Center Dr. #308, Rockville, Maryland 20850 31. DATE FILED (Month, Day, Year)

01 1995 ШМ

32. REGISTRAR'S SIGNATURE Whi Davidson Reveall May 27, 1995

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within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	mpletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 si	Centation or removal
law requires that the death certificate be executed	as been signed by the attending physician and cor	Next of Health and Mental Hymene prior to bur
IYSICIAN: The law requires that the dear	ns certificate has been signed by the attending physician and con	with the State Dent of Health and Mental Hymiene prior to bur
G PHYSICIAN: The law requires that the dear	ECTOR: After this certi	is after death with the State Dept of Health and Mental Hydiene prior to bur
IYSICIAN: The law requires that the dear	DR: After this certi	aath

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		C	ERITFIC	JAIL OF	DEATH	REG	NO.		
		1. OECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA	TH DAY	YEAR	3. TIME OF DEATH
	1	Douglas Carlton Gardner						May 28,	1995	TEAN	5:00 a. M
		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. la:		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	н	8. BIRTH	LACE (State or Foreign
_	1	065-16-6757	1 🕅 M 2 🗆 F	72	YRS.	ONTHS DAYS	HOURS MIN.	Nov. 12	1922	Nort	h Carolina
3 should		9a. FACILITY NAME (If not institution, give :	street and number)			b. CITY, TOWN	OR LOCATION OF D			NTY OF DE	
	E .	Shady Grove Adven	tist Nursi	ne Cen	ter	Rockvi	110		Mor	ntgom	OTH
2,	1 5	RESIDENCE OF DECEDENT		-6 0011	CCI	ROCKVI	116		MOI	regom	ery
sages	DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
permit. Pages 1, 2,		Maryland Montg	omery_		Germa	antown					1 TES 2 NO
perm	\¥	10e. STREET AND NUMBER				10	f. ZIP CODE	-	10g. CIT	ZEN OF W	HAT COUNTRY?
ansit	监	20509 Anndyke Way				2	0874		Unit	ed S	tates
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EX			13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Speci	fy Yea or No —	14. RACE	- American Indian, White, etc.
000 F 2 3	ВУ	1 Never Married 2 X Married 3 Widowed 4 Divorced	IF YES, GIVE WAR	OR OATES			2 NO Speci		(-)	Specify	1
15-0( tending as the			l WWI			1					White
21 afte	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	ECEDENT'S U	SUAL OCCUPATI rk done during mo retired.)	ON ost of working	16b. KIND O	F BUSINESS/INC	DUSTRY	
tal o	E	Elementary/Secondary (0-12)	Callege (1-4 or 5 +)					1			
.AND 2121 the hospital or ath detached for use once.	M		3	<u>Ca</u>	rpet S	Sales			Employe	ed	
the hos detach	8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, M	alden Surname)		
;, MARYLAND 21215-0020 be retained by the hospital or attending physician ge 5 should be detached for use as the burial-trane notifiled at once.	BE	Frederick Carlton	Gardner					Louise			
MARY retained b 5 should 1	70	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural				
E, N by be re bage 5		Margaret G. Gardn	er	2	0509 A	Anndyke	Way, Ge	rmantown	, MD 20	)874	
BALTIMORE, after death. Page 6 may be after funeral director, page moval.		20a. METHOD OF DISPOSITION 1 Burlet 2 X Cremetion 3 Rem	oval from State	20b. PLACE	AND DATE OF	DISPOSITION (N	ame of		c. LOCATION —		
O D O O O O O O O O O O O O O O O O O O		4 Donation 5 Other (Specify)	_	Metro	polita	an Crem	atory	5/28 A	1exandr	ia,	Virginia
BALTIN nours after death. Pag of in by the funeral dic or removal.		21. SIGNATURE OF FUNERAL SERVICE LA	DEMORE	)		22. NAME A	Funeral	CILITY			
AL death fune		<b>→ \</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1						0 - 4 + 1		- MD 00077
te AE		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate									
Si		shouk, or hadrt fallura.	Liat only one cause	on aach line	a.		out of the same	aa cardiac or	reapmatory arr	wat,	Intarval Between
		IMMEDIATE CAUSE (Final disesse or condition	M-44-4	. D.							Onset and Death
O. BOX 68760 entitin 24 entitions to physician and completely filling giene prior to burial, cremation, other traumatic event, the		reaulting in death)	Metastati			Carcin	oma				years
K 68760 executed within and completel o burial, crema matic event,			DUE TO (OR	AS A CONSE	OUENCE OF):						
K 6871 executed a and con to burial,	O	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF):							-		
BOX cate be en hysician a prior to	ATI	If any, leading to immediata cause. Entar UNDERLYING	40E 10 (0	A0 A 00113C	occitice or j.						i
, P.O. BOX leath certificate be a attending physician rital Hygiene prior to y, or other traur	CERTIFICATION	CAUSE (Disesse or Injury	c. DUE TO (OR	AS A CONSE	OUENCE OF						-
P.O. rth certific tending paid Hygien or other	Ē	that initiated events resulting in death) LAST	350 10 (31)	NO N 001102	oochoc or j.						i
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Ne Pe		PART II. Other algnificant condition	a contributing to das	ith but not	reaulting in	the undarlyin	g cause given in	Part i. 24a, W	S AN AUTOPSY		WERE AUTOPSY FINDINGS
ORE that the sed by the and he and in	EDICAL								RFORMEO? ES 2 X NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
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L RE faw requires been sept. of H	≥ :	DID TOBACCO USE CONT	RIBLITE TO CAUS	E OF DEA	TH YES		INCEDTAL	N D			. L tes 2 L MO
AL le law has t Dept	AN	25. WAS CASE REFERRED TO MEDICAL	MEDIL 10 CAUS			(Check only one)	UNCERIAL				
VITAL AN: The law tificate has e State Dep	Sic	EXAMINER?  1  YES 2 X NO	HOSPITAL:			THER:		AD au in			
크를	PHYSICIAN: M	27. MANNER OF DEATH	28e. OATE OF INJ		28b. TIME	-	Ne 5 Residence	6 Other (Specif) 28d. DESCRIBE F		CHBED	
O 돌림 등		1 X Netural 5 Pending	(Month, Day, Y		INJU	SA MC	ORK? YES 2 NO	AVG. DESCRIBE	OW HUURT OC	OUNED	
ON DING After death	BY	2 Accident Investigation	20- 81 405 05 19	MIRW ALL							
ISIC TTENDI TTENDI Affect d affect d		3 Suicide 8 Could not be	28a. PLACE OF IN building, etc.	(Specify)	ome, larm, atr	eet, lactory, offic	:4	281. LOCATION (S City or Town,	treet and Number State)	or Rural Ro	oute Number,
DIVISION OR ATTENDING I DIRECTOR: After hours after death Item 28 Is man											
DIV AL OR A AL DIREC 2 hours 1 Item	COMPLET		CIAN: To the best of my	knowledge, de	enth occurred	at the time, date	and place, and dua	to the cause(a) an	d menner as stat	ted.	
HOSPITAL FUNERAL WITHIN 72	S	one) 2 MEDICAL EXAMINE	R: On the basis of exami	nation and/or	investigation,	In my opinion, o	leath occured at the	time, date and pla-	ca, and due to th	ne cause(a)	and manner as stated.
HO: FUN	Ö	29b. SIGNATURE AND TITLE OF CERTIFIE	1		. ^		29c. LICENSE NU	MBER	29d, DAT	E SIGNED	Month, Day, Year)
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	ω	3 Aloud	9104	, 1	(1)		D31391				, 1995
₽₽₩ <b>%</b>	임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	F DEATH (ITE	M 27) (Type. P	rint)	וננונת		I MI	ay 20	
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1011		Suhair H. Abulfara 31. OATE FILEO (Month, Day, Year)	22. REGISTRAR'S	SIGNATURE	onegon	ery v1	TTAge AV	e. #G-10	, Gaith	erso	urg, MD
	l l	JUN 01 1995	22. REGISTRAR'S	or Rand	elle						
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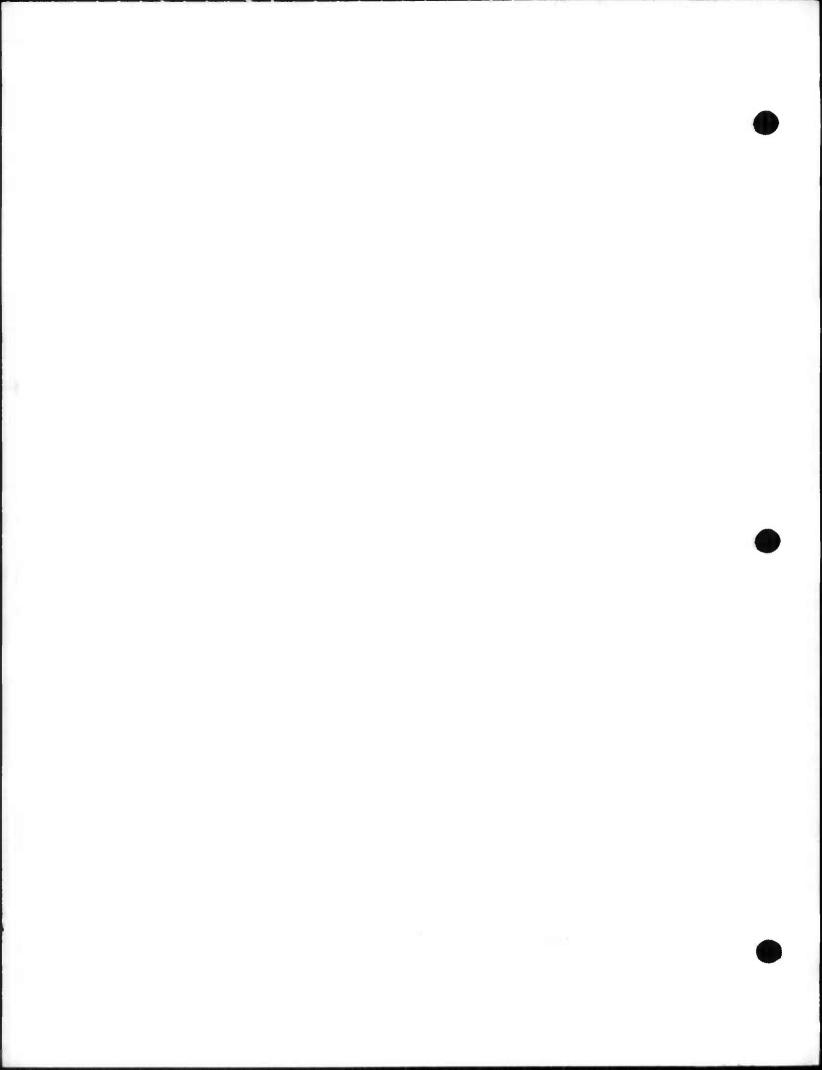
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flowing and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It flem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netitled at once.

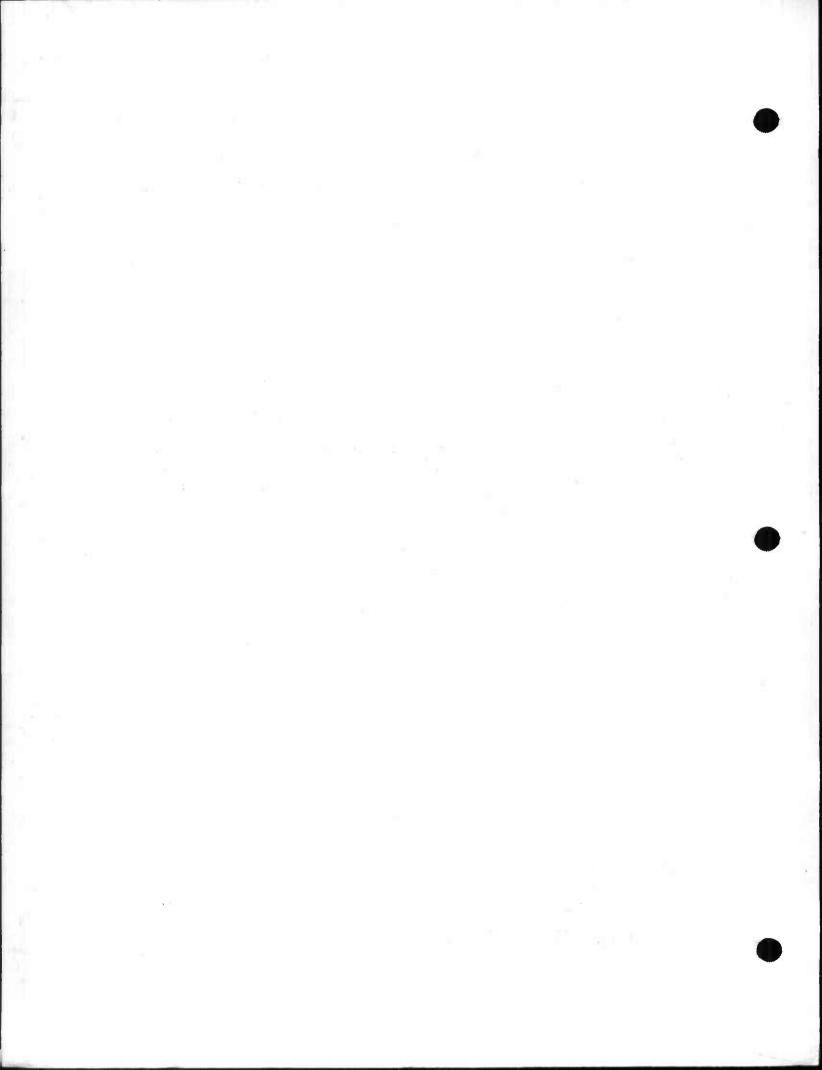
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN 3. TIME OF DE		
	Patric:			GUARIN	0	May 30,	1995	5:33 am M	
	4. SOCIAL SECURITY NUMBER 050-26-1140	1 [ M 2 X] F	GE (In yrs. lest birth	RS. IF UNDER 1 YEARS. DAY		Feb 27, 19	35 Ne	NPLACE (State or Foreign ry) W YORK	
or .	9a. FACILITY NAME (If not institution, give :			9b. CITY, TOW	OR LOCATION OF D		9c. COUNTY OF D	EATN	
DIRECTOR	6/71 Brace Court			Fred	erick		Fred	erick	
IRE	Maryland Free	derick	100	CITY, TOWN OR LO				10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	TELICK		Frede	CLCK		10g. CITIZEN OF V	1 YES 2 X NO	
ERA	6771 Brace Court				21701		U.S.		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 300	If yes,	ECENDENT OF NISPA	NIC ORIGIN? (Specify Year an, Puerto Ricen, etc.) fly:	or No- 14. RACI	E — American Indian, k, White, atc.	
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5 +)	(Give kin	INT'S USUAL OCCUPA and of work done during IOT use retired.)	TION most of working	16b. KIND OF BUSI	NESS/INDUSTRY		
COMPLET	12	College (Ind or 5 +)	Admir	nistrativ	Ass't	Veteran	s Admini	stration	
5	17. FATNER'S NAME (First, Middle, Last) Leonard	A 1 1			18. MOTNER'S NA	AME (First, Middle, Malden S	iumame)		
8	19a. INFORMANT'S NAME (Type/Print)	Allen		ONALD	Ida	Christine Route Number, City or Town,		AWSON	
2	Christine H. Guar	cino				ederick, Ma		21701	
	20s. METNOD OF DISPOSITION 1  Burial 2 X Cregiation 3 Ram	noval from State		ATE OF DISPOSITION			ATION — City or To		
	4 Donation 5 Other (Specify)	CENCEE	Smithsb	urg Crema	tory May	B1,1995 S	mithsbu	rg, Maryland	
	1/11/	(/()	)	Kee		sford P.A.			
-4	23. PART I. Enter the dispesse, or	complications that can	MOO70	106 1	Church	St Freder	i ala MD	21.701	
	ahock, or heert failure.  IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	a. ATHERD.	n eech line.	c caro		LAR 0156		Approximata interval Between Onset and Daath	
NO	Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):							
3	if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury	c						T I	
EHIIFICATION	that initiated eventa resulting in death) LAST	DUE TO (OR A	AS A CONSEQUENC	CE OF):					
2	PART II. Other aignificent condition	ne contributing to deet	h but not result	ing in the underly	ng ceuse given in	Part I. 24a. WAS AN A	UTOPSY 24b	. WERE AUTOPSY FINDINGS	
3		FNESS,				DEDECOR	IED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	LUCER, H	YPERTEN.	SIBN		/			OF DEATH?	
ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE				N 🗆			
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		OTHER:					
ZH.	27. MANNER OF DEATH	1 Inpatient 2 ER/C	RY 28b		me 5 Realdence	6 ☐ Other (Specify)  28d. DE\$CRIBE NOW IN.	ILIEN OCCUBED		
- 1	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	nr)	INJURY	YES 2 NO	204. DEGOTIOE NOW IN	JOHN OCCURED		
EDB	2 Accident 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)						d Number or Rural F	Poute Number,	
MPCE	29a. CERTIFIER (Check only 1 CERTIFYING PNYS	ICIAN: To the best of my ki	nowledge, death oc	courred at the time, d	te and place, and due	to the cause(s) and mann	er as stated.		
Š		ER: On the beels of exemine						) and manner as stated.	
OE (	29b. SIGNATURE AND TITLE OF CERTIFIED	O. Done	Non	mo	D2193		29d. DATE SIGNED	(Month, Dey, Year)	
=	30. NAME AND ADDRESS OF PERSON WN								
	Andrew O. Done	lson, M.D.,	915 Tol	llhouse A	zenue, Fr	ederick, Ma	ryland 2	21701	
	MAY 3 1 1990	32. REGISTRARIES	IGNATURE ROAD	alf (					



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

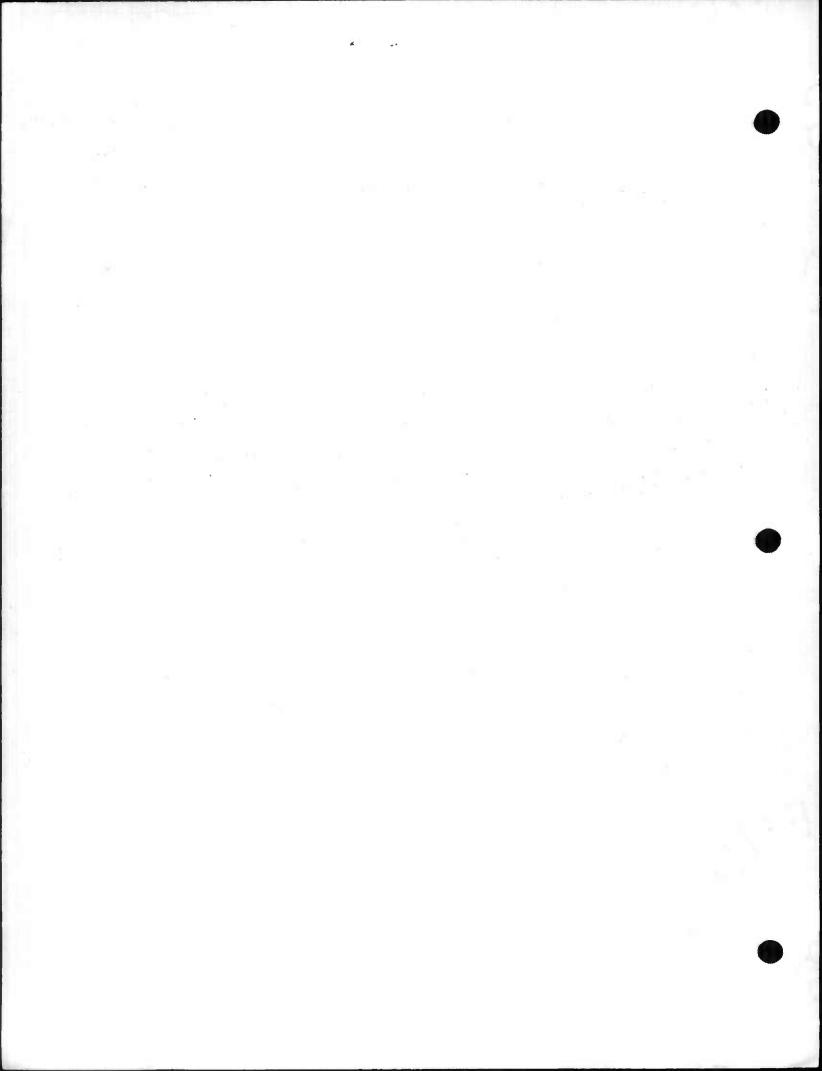
1	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
- 1	TICHO: Z	ART 1, 2/, 20a-r, PER MEU FILM G-/25 //6/95 t.t

_	REGISTRAR		CERTIF	ICATE OF DEATH	REG.	NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	NMT		CRIMPE	2. DATE OF DEAT		3. TIME OF DEATH	
	NICHOLAS  4. SOCIAL SECURITY NUMBER	NMI 5. SEX 6. AGE		GRANDE	MAY		95 9:12	
	369-58-7338	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRI MONTHS DAYS HOURS MIN	40.4 .4 .60 .44	1057	BIRTHPLACE (State or Fore Country)	
	9a. FACILITY NAME (If not institution, give str	22	37 YRS.				Japan	
Œ				9b. CITY, TOWN OR LOCATION OF			Y OF DEATH	
5	3031 GUILFORD A	AVE		BALTIMORE C	TTY	N/	A	
E S	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCATION			10d. INSIDE CITY	
DIRECTOR	Maryland N/A		Ва	altimore			1 X YES 2 N	
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?	
FUNERAL	3031 Guilford Ave	nue		21218			U.S.A.	
2	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECENDENT OF HIS If yes, specify Cuben, Mer	PANIC ORIGIN? (Specif	y Yes or No 1	4. RACE — American India: Black, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TES 2 NO Spi	ecity:	"	Specify: White	
	15. DECEDENT'S EDUC	ATION	150 DECEDENT'S	USUAL OCCUPATION	I see your or	BUSINESS/INDU		
E	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of a	work done during most of working	166. KIND OF	BUSINESS/INDU	SINY	
교	Elemental y Secondary (0-12)	3 years	Techni	ician	None	e		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				NAME (First, Middle, Me			
ш	Nicholas Grande				Adaline G			
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and Number or Ru	ral Route Number, City or	Town, State, Zip C	(ode)	
2	Nicholas Grande			Martha's Court				
	20a. METHOD OF DISPOSITION 1   ↑ Buriel 2 □ Cremation 3 □ Remo	val from State	. PLACE AND DATE	OF DISPOSITION (Name of		LOCATION CI		
	4 Donation 5 Other (Specify)	Mo	ount 01iv	vet Cemetery			k, Maryland	
	21. SIGNATURE DE FUNERAL SERVICE LICI	NSEE S		22. NAME AND ADDRESS OF ROBERT E. DA	FACILITY TIEV & SOI	N FINER	I HOMES P	
ä	No feet &	Ancey	17	1201 NORTH M				
CERTIFICATION	Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events  DUE TO (OR AS A CONSEQUENCE OF):  OUE TO (OR AS A CONSEQUENCE OF):							
SER	resulting in death) LAST							
	PART II. Other significant conditions	contributing to deeth b	out not resulting i	in the underlying ceuse given		AN AUTOPSY	24b. WERE AUTOPSY FIN	
EDICAL					1/	S 2 NO	AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?	
ME							1 YES 2 N	
AN	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S NO UNCERTA	AIN 🗆			
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT					
YSI	XXYES 2 NO	1 Inpatient 2 ER/Outp	patient 3 🗆 DOA	OTHER: 4 Nursing Home 5 Residence	ce 6 C Other (Specify)			
PHY	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM FOUND	URY WORK?	28d. DESCRIBE HO			
B	2 Accident Investigation	5-29-95 FOUN	ID 8:45	P M 1 YES X NO	SUBJECT IN			
	3 Suicide 8 XX Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	cify)		28t. LOCATION (Str. City or Yown, S	tate) 3031 GU	Rural Route Number, ILFORD AVE.	
<b>.</b> 1	AA- CERTIFIE		FOUND AT		BALTIMORE,	MD.		
탈	(Check only   CENTIFYING PHYSIC			ed at the time, data and place, end d				
COMPL	7	: Un the pasie of alterninatio	n end/or investigatio	n, in my opinion, death occured at t	the time, date end place	, and due to the	cause(e) end menner ee sta	
BE (	200. SIGNATURE AND TITME OF CERTIFIER	10		29c. LICENSE N	UMBER	29d. DATE S	BIGNED (Month, Day, Year)	
<u>و</u> ا	30. NAME AND ADDRESS OF PERSON WHO		4	0.C.	M.E.	MA	Y 30,1995	
	MARIO F. GOL	COMPLETED CAUSE OF DE	7111 PE	NN STREET BA	LTIMORE,	MARYLA	ND 21201	
	31. DATE FILEO (Morith, Day, Year)  JUN 0 2 1995	32. REGISTRAR'S SIGN	ATURE					
- 1	0011 0 2 1333	1	- Wartall					



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BALT	E HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	8
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	LLJ.

		REGISTRAR	STATE OF MARYL	AND / DE	PARTMENT (	OF HEALTH A	ND MEN	TAL HYGIEN REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)			G	ray	MA.	ATE OF DEATH DONTH DO	AY /	VEAR 3. TIME OF DEATH M
9		216-92-9831	□ M 2 X F 6	(In yrs. last birth			Acres (A	ATE OF BIRTH forth, Day, Year) OV. 14,	1925	BIRTHPLACE (State or Foreign Country) MARYLAND
2, 3 should	стоя	9a. FACILITY NAME (If not Institution, give atreet SURBURBAN HOSPITAL	and number)			OWN OR LOCATION ETHESDA	OF DEATH			Y OF DEATH NTGOMERY
Pages 1.	DIREC	10a. STATE 10b. COUNTY  MARYLAND MONTGO	MFDV	c. CITY, TOWN OR					10d. INSIDE CITY LIMITS?	
n. ansit permit.	ERAL	100. STREET AND NUMBER #5721 GROSVENOR LAN			BETHES	101. ZIP CODE 20814	<u>,</u>			IN OF WHAT COUNTRY?
215-0020 attending physician. ise as the burial-transit	BY FUNI		N U.S. ARMED	S. ARMED  13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puarto Rican, etc.)  14. RACE — American, Puarto Rican, etc.)  1 □ YES 2 ☑ NO Specify:  Specify:				4. RACE — American Indian, Black, Whita, atc.		
21 6 c	LETED		pleted) ollege (1-4 or 5+)	(Give kin life. Do N	ENT'S USUAL OCCI nd of work done duri VOT use retired.)	UPATION ing most of working		16b. KIND OF BUS	SINESS/INDU	
YLAND 2 by the hospital be detached to at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	ONE	N	ONE			NON rst, Middle, Maiden	Surname)	
MAR retained to 5 should notified	TO BE	JOHN GRAY  10a. INFORMANT'S NAME (Type/Print)  LODE NZO, CHARLES, CRA	37			Street and Number or	Rural Route I		n, State, Zip C	
ORE, 6 may be ctor, page nust be		LORENZO CHARLES GRA  20a, METHOD OF DISPOSITION 1 ABurlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cern	. PLACE AND D	DATE OF DISPOSITION or other place)	ON (Name of		ATE 20c. LO	CATION — CI	AD, MD, 20640 ty or Town, Stata
ALTIM death. Page funeral dir examiner		ST. CHARLES CEMETERY 6/8/95 GLYMONT, MARYLAND  22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME, P.A.  3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640								
within 24 hours after the spletch filled in by the cremation, or removal, the medical or mit, the medical or mit, the medical or med		23. PART I. Enter the disesses, or comshock, or heart feilure. List IMMEDIATE CAUSE (Final disesse or condition resulting in death)	plications that caused	the deeth. ach line.	Po not enter the	e mode of dying	, such aa d	cardiac or reapi	ratory arrei	Approximata Interval Between Onset and Desth
5, P.O. BOX 6870 death certificate be executed a attending physician and con- ental Hygiene prior to burial, iny, or other traumatic ex-	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):								
that the de by the h and Mer	MEDICAL (	PART II. Other significant conditions of	ontributing to death b	ut not result	ting in the unde	rlying causa giv	en in Part i	24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO
AL has the Dept.	SICIAN:	DID TOBACCO USE CONTRIB  25. WAS CASE REFERRED TO MEDICAL EXAMINER?			YES NO		RTAIN [			
HYSICIAN: The this certificate with the State ted, or item	PHYSIC	1 YES 2 NO 1	DSPITAL: 6 Inpetient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)			Home 5 Resid		Other (Specify) DESCRIBE HOW II	NJURY OCCU	RED
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Si Item 28 is marked, or it	ED BY	Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, ta	М	1 TES 2 A	26t. I	OCATION (Street a	nd Number or	Rural Route Number,
TAL OR 72 hour	COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: O								cause(a) and menner as stated.
TO THE HOSPITAL TO THE FUNERAL be fied within 72 IMPORTANT: If	TO BE CO	296. SIDNATURE AND FITLE OF CERTIFIER	h 14	t.p		29c. LICENS				GIGNED (Month, Day, Year)
	Ē	30 NAME AND ADDRESS OF PERSON WHO CO	MPLETEO CAUSE OF DE		(Typo, Print) Chardes	m/ 2	08/4	·+		
		JUN 0 8 1995	32. BEGISTRANS SIGN	ATURE PLANT	fall					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

								9	5 18513
	REGISTRAR	STATE OF MARYLAN				IEALTH AND DEATH		IENE NO.	
	1. DECEDENT'S NAME (First, Middle, Last)					- 001	2. DATE OF DEA	TH DAY	3. TIME OF DEATH
	LILLIAN P. GORDY	·		,		-ORDY	MAY	26	1995 1555 M
	The state of the s	. SEX 6. AGE (In yr	s. last birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, N 9-3-19	ar)	BIRTHPLACE (State or Foreign Country)     Md .
	9a. FACILITY NAME (If not institution, give street			9b. CITY	r, TOWN (	OR LOCATION OF D	EATH	9c. COL	UNTY OF DEATH
DIRECTOR	PENINSULA REGIONAL	MEDICAL CEN	TER		SALI	SBURY		W	ICOMICO
EC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWH	OR LOCAT	TION			10d. INSIDE CITY
E E	DE. Sussex			)elma					LIMITS?
AL A	10e. STREET AND NUMBER					. ZIP CODE		10g. CIT	TIZEN OF WHAT COUNTRY?
FUNERAL	Rt#2 Box 345					19940		US	SA
5		. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	ARMED				NIC ORIGIN? (Speci		14. RACE — American Indian, Black, White, etc.
ВУ	1 Never Merried 2 Merried  3XXWidowed 4 Divorced	IF YES, GIVE WAR OR DATES				2 X NO Specia	an, Puerto Rican, et fy:	2.)	Specify:
	15. DECEDENT'S EDUCATI	ION 16	. DECEDENT'S	I I I I	COLIBATIO	241	20. 20.0		White
	(Specify only highest grade con	college (1-4 or 5+)	(Give kind of life. Do NOT u	work done	during mo		16b. KIND C	F BUSINESS/IN	DUSTRY
<u> </u>	10	Ollege (1-4 or 5+)	Seamst	ress			Garme	it Co.	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S NA	AME (First, Middle, M		
BE (	Allen Parker					Lulu E	lliott P	arker	
2	19e. INFORMANT'S NAME (Type/Print)						Route Number, City		ip Code)
-	Susie L. Jarrett		Rt. #	2 Bo	x 34	5 Delman	r, De. 1		
	20e, METHOD OF DISPOSITION 1 Description   Method   Description   Descri		Stephe					elmar,	- City or Town, Stata De.
	21. SIGNATURE OF FUNERAL SERVICE LICENS	m ///				D ADDRESS OF FA			
	Wellen M.	Hot !					Home, In		10040
	23. PART I. Entar the diseases, of com shock, or heart fallure. List	plications that coused the	e death, Do	not enter	the mo	de of dylng, auc	h as cerdiac or	reapiratory ar	rreat, Approximate
	IMMEDIATE CAUSE (Final	Only ona cause on each	iina.	/-		6		al	Intarval Between Onset and Death
	disease or condition resulting in death)	(efrocio	7 V	7		Sardi	porio	しつか	sch omm
	Description (Control of Control o	OUE TO (OR AS A CO	NSEQUENCE O	F):					
NO	Sequentially list conditions, b	OUE TO (OR AS A CO	NSEQUENCE O	D.					Lags
RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	PAS	NSEQUENCE O	11	- 2				7
트	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A CO	NSEQUENCE O	F):		54.5	)		)
	resulting in death) LAST								
8	PART II. Other algnificent conditions co	ontributing to death but r	of resulting	In the us	declulos	a seuse alven la	Boot I as an	S AN AUTOPSY	
MEDICAL			ot resolving	ar the or	· Goriyini	g cause given in	PE	RFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
0							—   ¹□ Y	S 2 NO	OF DEATH?
	DID TOBACCO USE CONTRIB	UTF TO CAUSE OF D	FATH Y	:s 🖂 i	NO F	UNCERTAI			1 TES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEA			ONCERIAI			1.00
SIC		OSPITAL:  V Inpetient 2   ER/Outpatier	nt 3 □ DOA	OTHER		e 5 🗆 Reeldence	6 ☐ Other (Specific		
[ 품 [	27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 286. INJURY AT 286. DESCRIBE HOW INJURY OCCURED						CURED		
ВУ	II 190 Nitural 5   Pandino								
<u>a</u>	3 Suicide 8 Could not be 4 Homicide determined 28. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)  28. LOCATION (Street end Number or Rural Route Number, City or Rown, Stete)							r or Rural Route Number,	
Ä	290. CERTIFIER 1 CERTIFYING PHYSICIAN	Y: To the best of my knowledge	death occur	ad at the t	ime date	and alone and day		- 2010 100-0	
COMPLET									sted. the cause(e) end manner es stated.
1 11	296. SIGNATURE AND TITLE OF CERTIFIER	71				29c. LICENSE NUI			
BE (	/ nel / x	(1)				D2044		290. UA	TE SIGNED (Month, Day, Year)
2	20 NAME OUD A ODDEROLOG DEDOGU WITH OF	OMBI ETED CALIFE OF DEATH				シャンナフ	/		0/1/75

JOSEPH L RAFFE 31. DATE FILED (MONTH, Day, Year) MAY 3 0 1995

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RAFFETTO QUINCUT LOCUST

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	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should
1	ifter (	the /
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	3	20
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	with	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
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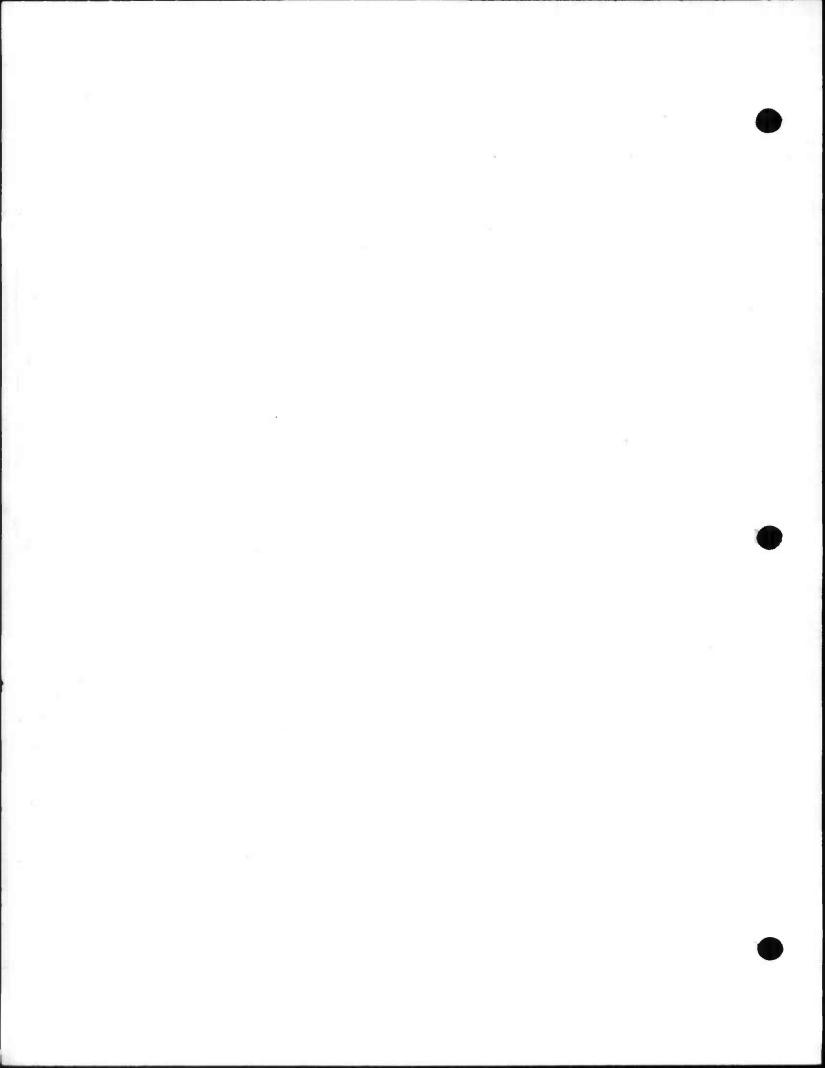
		STATE OF MARYLAN				MENTAL HYGIE!	NE	, 10011				
	1. DECEDENT'S NAME (First, Middle, Last) Anna Mary Green		CERTIF	ICATE OF	DEATH	2. DATE OF DEATH MONTH		a. TIME OF DEATH				
2	216-66-5668	□ M 2 💢 F	rs. lest birthday) 58 YRS.	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1		BIRTHPLACE (State or Foreign Country) Delaware				
. 2, 3 should	98. FACILITY NAME (If not Institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 99. COUNTY OF DEATH Elkton Cecil County											
permit. Pages 1, 2, AL DIRECTO	10a. STATE 10b. COUNTY	County		Y, TOWN OR LOC		breas File	10d. INSIDE CITY LIMITS?  1 YES 2 NO					
AL AL	TOT DE L'ULUSKI MIRMOV DIKLON											
the burial-transit  BY FUNER		. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	CENDENT OF HISPA	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		ted States  . RACE — American Indian, Black, White, atc.  Specily:						
for use as				USUAL OCCUPAT work done during n se retired.)		16b. KIND OF BU	JSINESS/INDUS	White				
5 should notified TO BE	Irma Mae Harris  196. INFORMANT'S NAME (Type/Print)  Mazie Campbell  701 E. Pulaski Highway, Elkton, Maryland 21921											
Nueral director, page xaminer must be	20s. METHOD OF DISPOSITION  1											
9 = 6	Robert T. Jones & Foard, Inc. 122 West Main St., Newark, DE 19711											
and competety filted in by the burial, cremation, or removal natic event, the medical of ON	23. PART I. Enter the desisse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due TO (OR AS A CONSEQUENCE OF):  Approximate interval Between Onset and Date of Consequence of the Consequence of											
The artenoing physician and con Mental Hygiene prior to burial njury, or other traumatic e. CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
dental Hygie ury, or of CERT												
Dept. of Health and Min 23 shows any injuried IAN: MEDICAL	PART II. Other algolficent conditions of	ontributing to death but r	not resulting	In the underlying	ng ceuse given in	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
State Dept. o	DID TOBACCO USE CONTRIB  25. WAS CASE REFERRED TO MEDICAL EXAMINER?			H (Check only one		N 🗆						
Z 6 ₽	1 YES 2 NO 1 (	Inpatient 2 ER/Outpaties  25a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. IN	JURY AT ORK?	6 Cher (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED				
after death 28 is mar	1 M Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s		YES 2 NO	281. LOCATION (Street City or Town, State)	and Number or I	Rural Route Number,				
Z = S	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN MEDICAL EXAMINER: 0	: To the best of my knowledge in the basis of axamination and						suse(a) and manner as stated.				
be filed within IMPORTANT:	296. SIGNATURE AND TITLE OF CENTIFIER	~p	29c. LICENSE NUI	MBER	29d. DATE SI	due to the cause(s) and manner as stated.  29d. DATE SIGNED (Month, Day, Year)  May 31, 1995						

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Northern Chesapeake Hospice
32 DEGISTRAN'S SIGNATURE
Julia Davidson Parkett

Dr. Henry Farkas 31. DATE FILED (Month, Day, Year) MAY 3 1 1995

239 S. Bridge St Elkton, MD 2192



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						74111	11 107	11 2 01	250		HEG.	VO.			
		1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH DAY YEAR  7. TOWN A TOWN THE DAY YEAR											3. TIME OF DEATH		
- 1											1995	12:20 p M			
		4. SOCIAL SECURITY NUMB	S. SEX	6. AGE (In	yrs. last birtho	lay) IF L	MDER 1 YEAR	IF UNDE	R 24 HRS.				HPLACE (State or Foreign		
	1	241-14-8958	89		MONT		HOURS	MIN.	(Month, Day, Year		Coun	etry)			
				1 M 2 X F	09	- "	77.				Jan. 6,	-		rth Carolina	
	~	9e. FACILITY NAME (If not in:					9b.	CITY, TOWN	OR LOCAT	ION OF DE	EATH	9c. C	OUNTY OF	DEATH	
	Ö	Laurel Regi	lonal I	Hospital			I	Laurel				Pr	ince	George's	
	2	RESIDENCE OF DEC	10b. COUNTY						100				A		
	DIRECTOR					10c.	CITY, TO	WN OR LOCA	TION				10d. INSIDE CITY		
	- 1	Maryland	Calv	rert			I	usby	_					1 TES 2 NO	
	4	10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN									CITIZEN OF	WHAT COUNTRY?			
-1	FUNERAL	928 Crystal Rock Road 20657 U.S.A.													
	5	11. MARITAL STATUS		12. WAS DECEDEN				13. WAS DEC			HC ORIGIN? (Specify			E — American Indian,	
- 1		1 Never Married 2		FORCES? 1				If yes, sp	ecify Cube	ın, Mexice	n, Puerto Rican, etc.		Blac	ck, White, etc.	
- 1	ВУ	3 🔀 Widowed 4 🗌 Divo	rced					1 🗆 160	2 00 NO	Speciny			Spe	White	
	B		EDENT'S EDUC		1			AL OCCUPATI			16b, KIND OF	BUSINESS/	INDUSTRY	WILLEC	
	E 1	(Specify only Elementery/Secondery (0-	highest grade	College (1-4 or 5		(Give kind life. Do NO	of work of Tuse reti	ione during mo red.)	ost of worki	ng					
	립	Listing in the state of the sta		1	·	Manag	er				0 & S				
nce.	COMPLET	17. FATHER'S NAME (First, MI	iddle, Last)						10 MOT	HED'S NA	ME (First, Middle, Mei	ton Common	-1		
2		Martin Luth		hort									•)		
Pe	BE	19a. INFORMANT'S NAME (7)		ibert		I					Ann Lar				
틩	임	Joe M. Clea									Route Number, City or				
9						0/01	Mon	tour	Drive	e, Fa	alls Chur	ch, V	/irgi	nia 22043	
표		20a. METHOD OF DISPOSITI		oval from Stata	20b. P	LACE AND DA	TE OF DIS	SPOSITION (No	ema of		DATE 20c.	LOCATION	— City or T	own, Sista	
Ē	1	1 M Burlei 2 Cremetton 3 Removal from State  4 Donestion 5 Other (Specify) Fort Lincoln Cemetery 5/25/1995 Brentwood, Maryland													
ine		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.													
жаш		1113	_												
a e	-	4739 Baltimore Ave., Hyattsville, MD 20781													
ig o		23. PART i. Enter the diseases, or complications that ceused the daeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert failure. List only one cause on each line.  Approximate interval Between													
E		IMMEDIATE CAUSE (Fine) Onset and Death													
or other traumatic event, the medical examiner must be notified at once.		disease or condition											minutes		
Ven			,			ONSEQUENC								maria ces	
5	z	Congestive Heart Failure 2 days													
E	CATION	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):													
Į.	8	cause. Enter UNDERLYING Hypoxemia											1 days		
her	Ĕ	CAUSE (Disease or injust that initiated events	η,			ONSEQUENC	E OF):							1 days	
0 10	CERTIFI	resulting in death) LAST	T .	Multilo	bar P	neumo	nia							7 days	
	뜅			-						_				, days	
ows any injury,	DICAL	PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY FINDINGS													
au	일Ⅱ	Urosepsis,	Arteri	osclerot	ic Ce	rebro	vasc	ular I	Disea	se		ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
W.S										_	' U 'E'	2 (K) NO		OF DEATH?	
5	2	DID TOBACCO U	SE CONTE	DIRLITE TO CA	LISE OF	DEATH	VEC F	T NO F	7 11516	'EDTA IA				1 TYES 2 NO	
ន	AN	25. WAS CASE REFERRED TO		CIBOTE TO CA		PLACE OF E				ERTAIN	Y29				
Hem	SICI	EXAMINER?	MEDICAL	HOSPITAL:			OT	HER:							
	Z ∥	1 TYES 2 X NO		1 1 inpetient 2		ent 3 🗆 DO			ne 5 🗆 Re	eldenca	6 Other (Specify)				
ed.	PHY	27. MANNER OF DEATH	55%	28e. DATE OF (Month, D		28b.	TIME OF	28c. INJ WC	JURY AT		28d. DESCRIBE HO	W INJURY	OCCURED		
	B		Pending Investigation						YES 2	NO					
90	اه		Could not be	28e. PLACE C	F INJURY -	At home, ler	m, street,	lectory, offic	:0		281. LOCATION (Stre City or Town, St		ber or Rural	Route Number,	
CA	EE	4 Homicide	setermined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						ony or rown, or	no,			
Hem	ון ב	29a. CERTIFIER 1 X CERTI	IFYING PHYSI	CIAN: To the heet of	my knowled	ne death oc	usemel et	the time date	and store		to the cause(s) and		diffice.		
	COMPL													s) and manner se stated.	
IMPORTANT: If	8							my opinion, c	rearn occu	an at the	time, data and place	ena dua lo	rne cause(	s) and manner as stated.	
- CA	W	296. SIGNATURE AND TITLE	OF CERTIFIER	111-					29c. LIC	ENSE NUN	MER	29d. D	ATE SIGNE	D (Month, Day, Year)	
¥		WW	N	Wa	M	en	W	7	D.	13916	5		May :	23, 1995	
	유	38. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEAT	H (ITEM 27) (	ype, Print)								
		Dr. William A. Warren, M.D. 321 Prince George Street, Laurel, Maryland 20707													
		31. DATE FILED (Month, Day, )	Year)	32, REGISTRA	R'S SIGNATI	URE		JULIE	, - 50		, Dudler	nal	y Lanu	20/0/	
		MAY 31/199	5 Ja	32 REGISTRA	rhade	R									

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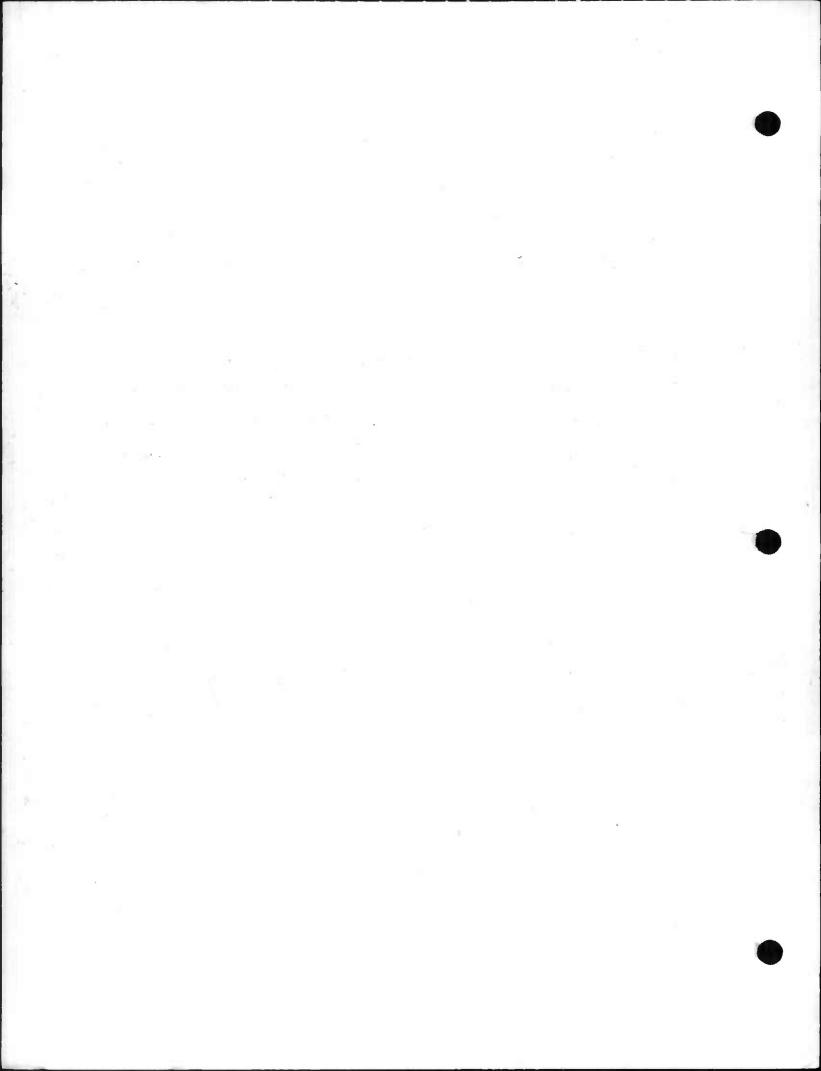
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDIAD PHYSICIAN. The Law isquires that the dean cartificate be executed with Secret hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL DIRECTOR After this centralist has been sepred by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 hours after death with the seprember of the property of the

Item23a, partl, item27, Film724, 6/26/95, 1t

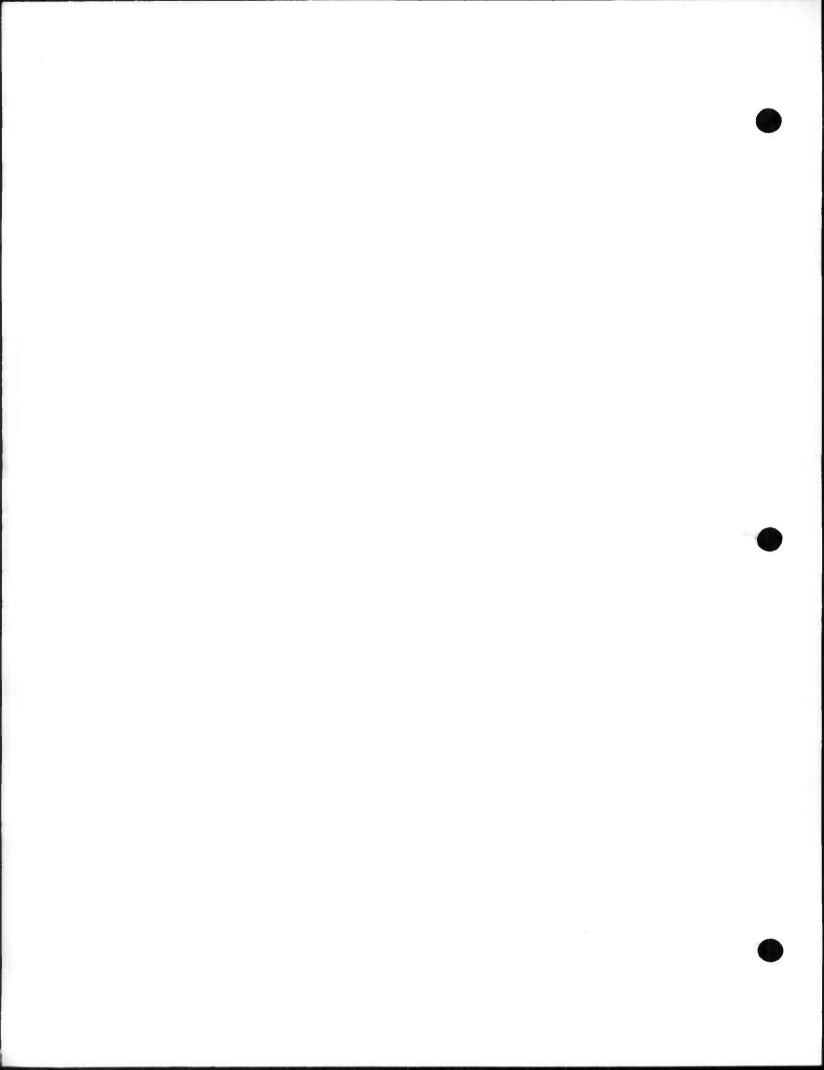
	1 - STATE REGISTRAR	STATE OF MA		ARTMEN IFICAT				MENTAL HYGIEI REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)  WILLIAM L.	GREEN						2. DATE OF DEATH MONTH	DAY	YEAR 1995	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest birthd	ay) IF UND	ER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	.0,		IPLACE (State or Foreign	
	219-76-7099	1 XM 2   F	35 YR	S				DEC.22 1	959		YLAND	
DIRECTOR	9a. FACILITY NAME (If not institution, give str NORTH ARUNDEL I		E.R.		VAPO	LIS	ON OF DE	EATH		VE A	RUNDEL	
EC	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c.	CITY, TOWN	OR LOCAT	ION					10d. INSIDE CITY	
	MD N/A	A	BA	ALTIMO	ORE						LIMITS?	
IAL	10e. STREET AND NUMBER				101	ZIP CODE			10g. Cl	TIZEN OF	WHAT COUNTRY?	
FUNERAL	3110 SEQUOIA AVENU					1215				TED	STATES	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES 2 NO	If yes, specify Cuban, Maxican, Puarto Rican, stc.)  Blac  1 YES 2 NO Specify: Spec						E — American Indian, k, Whita, atc. lly: ACK		
ED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	16a, DECEDEN					16b. KIND OF BU	JSINESS/IN			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	of work don Tuee retired.	)	st or worlding	7					
MP	12	1	LETTER	CARI	RIER			U.S. PO		SERV	ICE	
	17. FATHER'S NAME (First, Middle, Last) WILLIAM L. GREENE	CD						ME (First, Middle, Malde				
BE	19a, INFORMANT'S NAME (Type/Print)	SK.	10h MAII	ING ADDRE	RC /Crmat o	GER	CRUD	E MADORA ]	BULLO	CK G	REENE	
2	GERTRUDE M. GREENE	7.						EVERNA PAI				
	20a. METHOD OF DISPOSITION		20b. PLACE AND DA	TE OF DISPO	SITION (Na		11,5		CATION -			
	1 Surial 2 Cremetton 3 Remon	val from State	MARY LAND	or other place NAT	ONAL		JU	NE 1 95 L	AUREL	MAR	RYLAND	
	21. SIGNATURE OF PUNERAL SERVICE LICE	DISEE				D A CON	S OF FA	CILITY NERAL HOMI				
	· With	Bora	276					NERAL HOMI EET, N.W. V			20010	
~	IMMEDIATE CAUSE (Final disease or condition resulting in death)	disease or condition A CHITE A CHIMA										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
H	resulting in death) LAST											
PHYSICIAN: MEDICAL	PERFORMEO?  1 PERFORMEO?  OF									WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1927ES 2 NO		
ž	DID TOBACCO USE CONTR	BUTE TO CAUS	SE OF DEATH	YES	NO [	UNC	RTAIN	1 🗆				
당	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL :	26. PLACE OF D									
KSI		HOSPITAL:			irsing Hom		idence	8 Other (Specify)				
ВУ РН	27. MANNER OF DEATH  1 Netural 5 Perioding 2 Accident Investigation	28a. DATE OF IN. (Month, Day,	Year)	TIME OF INJURY M	1 🗆 1	RK? 'ES 2 🗍	NO	28d. DESCRIBE HOW	INJURY OC	CCURED		
- 0	3 Suicide 8 Could not be 4 Homicide datarmined	IJURY — At home, fair . (Specify)	m, street, fa	ctory, office			281. LOCATION (Street City or Town, State		nd Number or Rural Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI (Check only one) 2 MEOICAL EXAMINER:							to the cause(s) and ma			) and manner sa stated.	
BEO	296. SIGNATURE AND TUTLE OF CERTIFIER	M	//			29c. LICE	NSE NUM	IBER	29d. DA	TE SIGNEO	(Month, Day, Year)	
0	TO NAME AND ADDRESS OF THE		u			0.	C.N	1.E.		May	27 1995	
	30. NAME AND AODRESS OF PERSON WHO	Fowle	111		Str	eet,	_Bā	altimore	Mar	ylan	d 21201	
	MAY 301995 July	32. REGISTRAR'S	SIGNATURE									



1 - FOR STATE REGISTRAR

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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND DEATH	MENTAL	HYGIENE REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O MONTH	F DEATH DAY	YI	EAR 3.	TIME OF DE	EATH
		EDNA 4. SOCIAL SECURITY NUMBER	MAE 5. SEX 8. AGE (		NK		May 2				3:20	P
Pin		234-68-4810	1 □ M 2 🎇 F	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	April	Day, Year) L 24,19	13 1	West	Virg	
2, 3 should	DIRECTOR	9a. FACILITY NAME (if not institution, give s Memorial Hospi			St. CITY, TOWN Cumbe	or Location of a	HATH	9	A11	of DEAT		
es 1.	EC	10a, STATE 10b, COUNT	1	10c. CIT	Y, TOWN OR LOCA	ATION					d. INSIDE CI	ITY
permit. Pages		WV M1	neral		Keyser	of, ZIP CODE				1 (	LIMITS?	NO NO
TST.	ERA	P.O. Box 925	Mill Meadow	Trailer		26726		1		USA		
21215-0020 al or attending physician. for use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1	12. WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	INT EVER IN U.S. ARMED  1 YES 2 NO If yee, specify Cuben, Maxican, Puarto Rican, etc.)						4. RACE — American Indian, Black, White, etc. Specify:		
	ED	15. DECEDENT'S EDU (Specify only highest grade		16a, DECEDENT'S	USUAL OCCUPATI	ION	16b, K	IND OF BUSINE	SS/INDUST		Vhite	
YLAND 21.  by the hospital or be detached for u  at once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homem	e retired.)	ost or working	0 "					
the horderch	NO.	17. FATHER'S NAME (First, Middle, Last)			ancı	16. MOTHER'S NA	AME (First, Mic		1_Home			
N Pe	BE 0	Eddie Columbus	Kalar			Ara	Bell I	rons				
BALTIMORE, MARYLAND  int death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached had. il examiner must be notified at once.	0	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number	City or Town, S	tate, Zip Coo	de)		
E, P		Phyllis Bowman			5, Box		ser, W	7				
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		1X Burial 2 Cremation 3 Rame 4 Donation 6 Other (Specify)	oval from State com	PLACE AND DATE O	her place)	may	, 30 DATE	20c. LOCAT		_		
ALTIM death. Page funeral direc		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	SLIAWII M	22. NAME A	Gardens	CILITY		ale,	Mary	land	
ALTIN death. Pag e funeral dir f. examiner		1 Brun	S Smith	1		truck-Sm:					04=04	
ic a at		23. PART I. Enter the diseases, or o	complications that caused	tha death. Do n	ot enter the me	S. Main ode of dylng, aud	Stree	c or reepirate	ser, ory arreat,	, W V	26726 Approxi	
in 24 ely fille ation.		IMMEDIATE CAUSE (Final disease or condition	List only one ceuse on ed  CEREBROYAS  DUE TO (OR AS A			·						Between and Death
P.O. BOX 68' h certificate be execute anding physician and c Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):										
records,  w requires that the deat been signed by the atte pt. of Health and Mental shows any Injury,	MEDICAL	ASPIRATION PNEUMONIA  1 Ves 2 Ho  OF									RE AUTOPSY MLABLE PRIO MPLETION OF DEATH?	OR TO
		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S I NO E	UNCERTAI	N					
F VITAL SICIAN: The law certificate has the State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:	ne 5 🗆 Rasidence	B □ Other (	Snectful				
HYSICIA HYSICIA HIS Certif with the	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIMI	OF 28c. IN	JURY AT		RIBE HOW INJU	RY OCCUR	ED		
ON O DING PHYS After this death with	ВУ	1 Natural 5 Pending 2 Accident Investigation	(110111, 101)			YES 2 NO						
TTENDI TTENDI TTOR: A after de	ETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	treet, factory, offic	ca .	28f. LOCATI City or	ON (Street and a Town, State)	Number or F	tural Route	Number,	
DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT: If item	COMPLE		CIAN: To the best of my knowl R: On the basis of examination							iuse(s) sni	d manner as	s stated.
HE HE BE WE WE WILL	BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29	d. DATE SI	GNED (Mo	nth, Day, Yea	ır)
5 5 8 M	9	/ / / Taw				D 1486	5		May	12	7 19	795
1/		Dr. R. Barrera	Memorial Ho			Bldg. Cu	mberla	and. MI	215	02	1	
7		JUN 0 2 1995	132. REGISTRAR'S SIGN			_ 0.		,		-		



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Ronald J. Shumacher, M.D.

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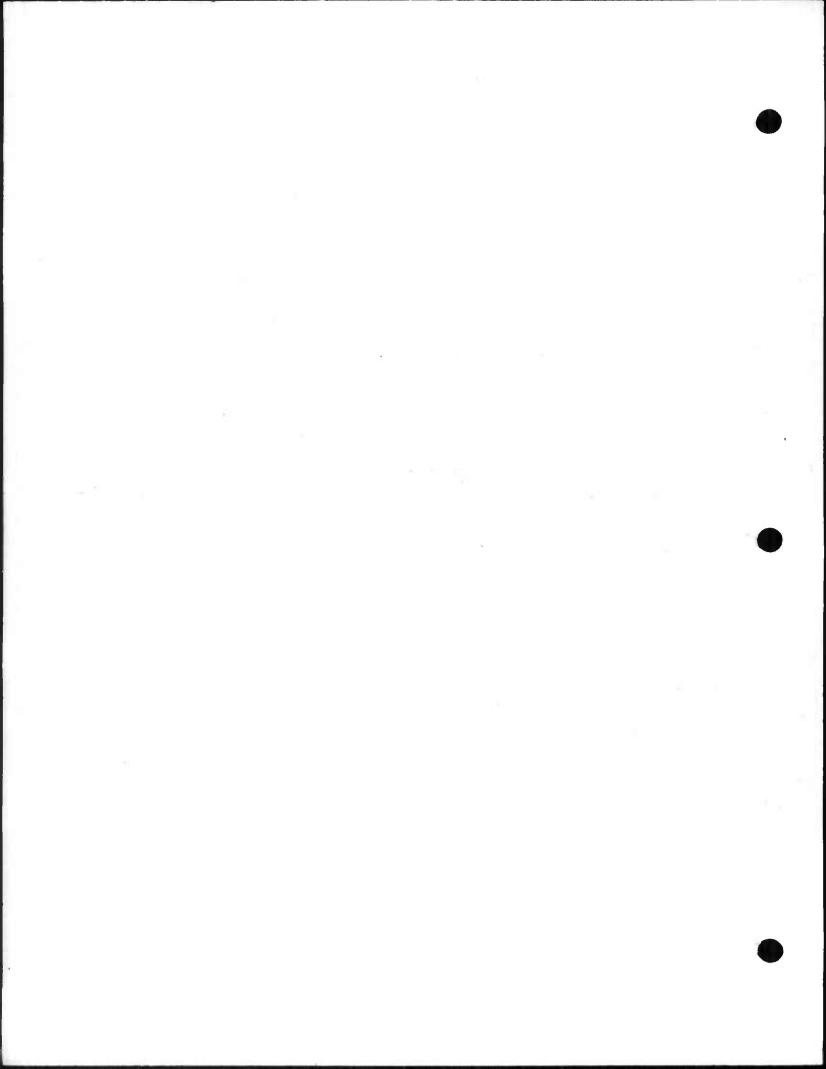
31. DATE FILED (Month, Day, Year)

32. REGISTRAN'S SIGNATURE

	FOR 1 - STATE REGISTRAR	STATE OF MA				HEALTH AND	MENT		E		010		
			- CE	HIIFIC	AIE OF	DEATH	_	REG. NO					
1	1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATH DAY YEAR 3. TIME			
	Helene Cecile Herold							30,			3:00 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. las	//	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH	8.		CE (State or Foreign		
	109-36-6391	1 M 2 K F	94	YRS, MC	NTHS DAYS	HOURS MIN.		oth, Day, Year) . 12, 1	900	Country) New Y	ork		
	9a. FACILITY NAME (If not institution, give at	treet and number)		91	CITY TOWN	OR LOCATION OF D		. 121 1	9c. COUNT				
œ			+0.2						30. COUNT	OF DEATH			
CTOR	Potomac Valley Nu	irsing cen	ter		Rock	ville			Mon	tgom	ery		
ш	10a. STATE 10b. COUNTY	,		10c, CITY, T	OWN OR LOCA	ATION				104	I, INSIDE CITY		
뜸	Maryland Mon	tgomery			otomac						LIMITS?		
	100. STREET AND NUMBER	cgomery		P							YES 2 NO		
ERAL					14	Of. ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?		
1 9	11056 Powder Ho	rn Drive				20854			Uni	ted S	tates		
FUNI	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1			13. WAS DE	CENDENT OF HISPA	NIC ORIG	IN? (Specify Yes	or No- 14		American Indian,		
BY	1 Never Married 2 Married 3 X Widowed 4 Divorced	IF YES, DIVE WAR			1 TYE	pecify Cuben, Mexic S 2 NO Speci	an, Puerro Vy:	Hican, etc.)		Black, WI Specify:	wia, atc.		
	3 A widowed 4 Divorced										White		
	15. DECEDENT'S EDUC (Specify only highest grade				UAL OCCUPAT		16	b. KIND OF BUS	SINESS/INDUS	TRY			
i iii	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use re	tired.)	lost or working							
.   ₫	12			Home	emaker			Own	Home				
once.	17. FATHER'S NAME (First, Middle, Last)				-	18. MOTHER'S NA	AME (First	Middle Maiden	Sumama)				
E C	Peter Leonard					100		74, 3474	out that they				
3 8	19a. INFORMANT'S NAME (Type/Print)		101	MARING AD	DDECC (Commit	Mary	-						
TO BE COM						and Number or Rural							
2	Rosemary Calvit					Horn Dr							
must	20a, METHOD OF DISPOSITION 1 IX Burlai 2 Cremation 3 Ramovel from State  20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)  20c. LOCATION — City or Town, State												
E	4 Donation 5 Other (Specify) Holy Cross Cemetery Lackawanna, New York												
=	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE 11	M00	831	22. NAME A	ADDRESS OF FA	CHUTY	v Funer	al Ho	me/			
Injury, or other traumatic event, the medical examiner	Tribana Sh M	Mullan	Lawro	MCQ	Rockv	ille, Ind	31	00 West	Mont	gomer	У		
<u></u>	22 PART I Enter the difference of a	7	1	/1	Avenu	e, Rockv	ılle	, Maryl	and 2	0850-	2805		
D D	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line.  Approximate interval Between												
9	IMMEDIATE CAUSE (Finel												
=	disease or condition resulting in death)	Arteri	oscler	otic C	ardiov	ascular	Dise	ase			20 years		
Ven		DUE TO (OI	R AS A CONSEQ	UENCE OF):							4		
2 Z													
	Sequentially list conditions, if any, leading to immediate	DUE TO (OI	R AS A CONSEQ	UENCE OF):						-			
E E	cause. Enter UNDERLYING									- 1			
真匠	CAUSE (Disease or injury that initiated events	DUE TO (OI	R AS A CONSEO	UENCE OF):									
RTIFICATION	resulting in death) LAST									- 1			
CE IS		·											
를	PART ii. Other significent conditions	contributing to da	ath but not re	eaulting in t	he underlyir	ng cause given in	Part i.	24a. WAS AN	AUTOPSY	24b. WEF	RE AUTOPSY FINDINGS		
DICA	Dehydration, Ma	lnutritio	n					PERFOR			ILABLE PRIOR TO IPLETION OF CAUSE		
8 B								1   YES 2	X) NO		DEATH?		
shows:	DID TORACCO USE CONTR	UDUITE TO CALL	CE OF DEAT	F11 - V/E6		7				1 [	YES 2 X NO		
S A	DID TOBACCO USE CONTR	GBUTE TO CAUS					K N						
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACI		Check only one	)							
	1 TYES 2X NO	1 Inpatient 2 E	R/Outpatient 3			me 5 🗆 Residence	6 🗆 Oth	er (Specify)					
	27. MANNER OF DEATH	28a. DATE OF IN. (Month, Day,		28b. TIME OF		JURY AT ORK?	28d. DE	SCRIBE HOW IN	JURY OCCUP	RED			
marked, BY PH	1 K Natural 5 Pending 2 Accident Investigation	(		WOON		YES 2 NO							
\$ 0	3 Suicide a Could not be	28s. PLACE OF II	NJURY — At hor	ne, farm, stree	et, factory, offic	ce	281. LO	CATION (Street a	nd Number or	Rural Route	Number,		
99 III	4 Homicide determined	building, atc	. (Specify)				City	or Town, State)					
E W	29a. CERTIFIER . 17												
MPL MP	(Check only   CERTIFYING PHYSIC												
MPORTANT: IL	2 MEDICAL EXAMINER	7: On the basis of exam	nination and/or in	vestigation, is	n my opinion,	death occured at the	time, det	a and place, and	due to the c	euse(a) and	menner es stated,		
E C	29b. SIGNATURE AND TITLE OF CERTIFIER	E .				29c. LICENSE NUI	MBER		29d. DATE S	IGNED (Mor	oth, Day, Year)		
S 9	406 5	9 0	00			D419	31	Į	▶ May				
를 일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH OTEM	PT (5 0-4	-41	D413	7.1		May	30,	TAAD		

2309 Shorefield Road, Wheaton, Maryland

20902-1825



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an about state death. Page 6 may be retained by the bloopial or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

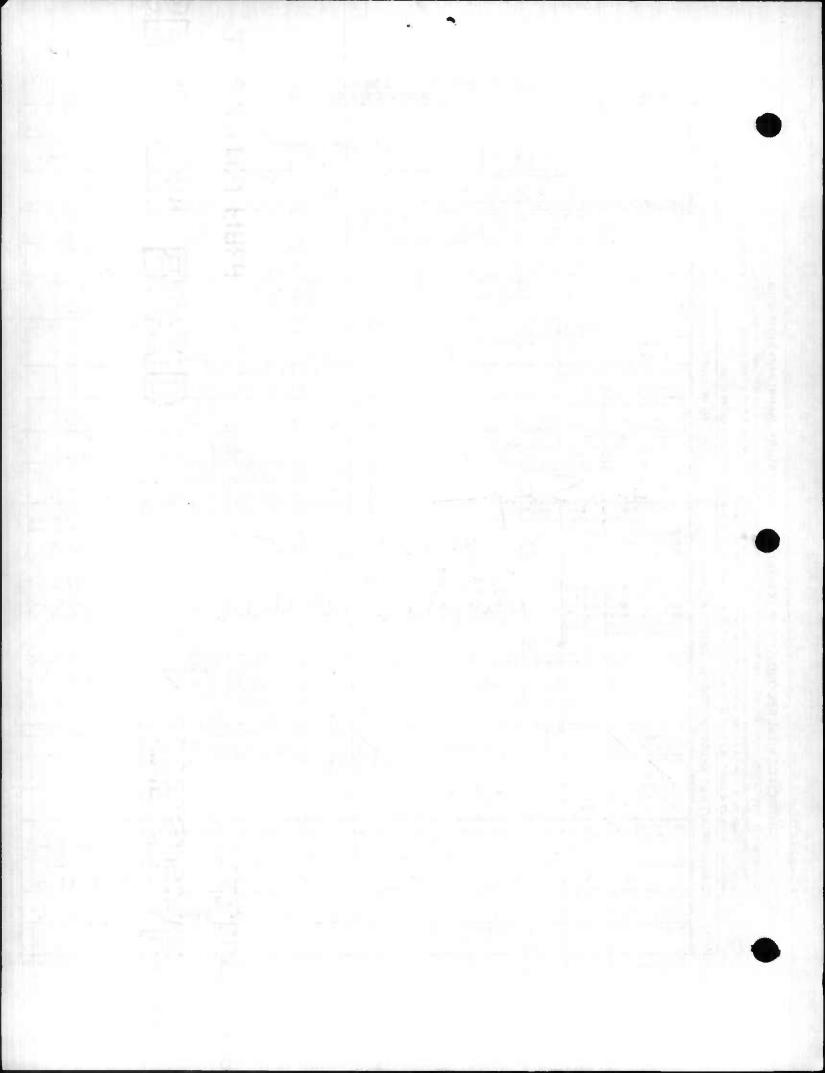
IMPORTANT: If them 28 is marked, or tem 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Jessie	Middle, Last)	Hedv	vig		F	lofe	rek		2. DATE OF DEATH MONTH June 6, 1	3. TIME OF DEATH 6:25 D M			
	4. SOCIAL SECURITY NUMB	ER	5. SEX	B. AGE (In yrs. les	t birthday)	birthday) IF UNDER 1 YEA				7. DATE OF BIRTH		6. BIRTI	ADI ACE (State or Coming	
	137-28-9681		1 🗌 M 2 💢 F	81	81 YRS. M			WS HOURS MIN,		April 24,	1914	Count	New Jersey	
	De. FACILITY NAME (If not int	stitution, give a	treet and number)					OR LOCATI		EATH	9c. COL	INTY OF E	DEATH	
OR	Potomac Val		Rockville							lontgomery				
5	RESIDENCE OF DEC	100 017	Y. TOWN	OB LOCA	LION				10d, INSIDE CITY					
DIRI	New Jersey	ESS				3100n	nfie.	ld		Times	1 🖔 YES			
₹	100. STREET AND NUMBER 79 Irving T				10	r. ZIP COO			WHAT COUNTRY?					
N	11. MARITAL STATUS	errace							7003			J.S.A		
BY FUNERAL DIRECTOR	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Was DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES						If yes, sp		in, Mexica	NIC ORIGIN? (Specify Ye in, Puetto Rican, etc.) y:		14. RACE — American Indian, Black, White, etc. Specify: White		
E	15. DECI (Specify only	EDENT'S EDU	CATION (COMOleges)	16e. DE	CEDENT'S	USUAL O	CCUPATIO	ON of world	200	16b. KIND OF BU	SINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	+)	. Do NOT u	se retired.)			''Y	100				
MP	Grade 12			Re	egist	erec	Nu	rse		Heal	th Ca	are		
8	17. FATHER'S NAME (First, MI									ME (First, Middle, Malden	Surname)			
BE	Joseph Ruck									Gruchaz	100			
0	19a. INFORMANT'S NAME (7)			19						Route Number, City or Tov				
	Mary Judith		cek					de Ro	oad				20878	
	20s. METHOD OF DISPOSITION  1													
	21. SIGNATURE OF FUNERAL	CENSEE		22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A.										
	1 (Trey	X	1/1							Avenue L			20707	
	23. PART I. Enter the di	seases, or o	complication the	at caused the de	eth. Do	not enter	the mo	de of dy	ing, suc	th as cardiac or reap	iratory a	rreat,	Approximate	
	shock, of heart fellure. List only of ceuse on each line.  IMMEDIATE CAUSE (Final												Interval Between Onset and Death	
	disease or condition											mos.		
	DUE TO (OR AS A CONSEQUENCE OF):										MIOZ.			
2	TURD IT NIGHTED											WK.		
2	Sequentially list conditi if any, leading to immed	DUS TO	BUENCE O	F):	1				11		713			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  d.										mo		MOS.	
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
MEDICAL		-		osadir bat not i	Jeoning		looriyiii	A c=000	given in	PERFD	RMED?	MAILABLE PRIOR TO		
										1 TYES	2 🛮 NO		OF DEATH?	
-	-				_								1 YES 2 ND	
AN	25. WAS CASE REFERRED TO	MEDICAL			_		20.00	1 AOE OE E	FATH ON	neck only one)				
i i	EXAMINER?		HOSPITAL:	ER/Outpatient 3	Пер	OTHE	R:				_			
PHYSICIAN:	27. MANNER OF DEATH		26e. DATE OF		28b. TIN			NO 5 LJ R	esidence	6 Other (Specify) 28d. DESCRIBE HOW	BY HIBA OV	CHIPED		
		Pending	(Month, L			JURY	WC	PRK7 YES 2 [	□ NO	200. DESCRIBE NOW	insoni o	CONED	0.84	
В	2 0 0 444	investigation	28e, PLACE (	OF INJURY — At he	ome, farm,	atreet, fec				28f. LOCATION (Street	and Numbi	or or Rumi	Route Number	
		Could not be determined	building	atc. (Specify)			,			City or Town, State		a or more	route reprised,	
	29a. CERTIFIER										0.0	-0.0	-	
COMPLETED	one)									to the cause(a) and ma time, data and place, e			e) end menner ee stated.	
ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	Da					29c. LIC	ENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)	
TO B	8	Hell	approx	41	ML			D	373	39)	>2	me	7.1995	
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	Dr. Suhair				. Mon	tgom	ery	Vill	age	Ave. #Gl	Gai	ther	sburg, Md.	
	31. DATE FILED (Month, Day,			AR'S SIGNATURE	1 11							71 - 1		
- 4	JUN 0 8	ככבו נ	Hava di	mener was	dall									

DHMH-16 Rev 1/89



			FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF			YGIENE EG. NO.			
	17.		1. DECEDENT'S NAME (First, Middle, Last)	Robert	Hos	stott	2R	DATE OF B	e ay 19	AGUS 3. III	ME OF DEATH	
	P		4. SOCIAL SECURITY NUMBER 218-01-2636	1 🔀 M 2 🗆 F	76 YRS.	MONTHS DAYS	HOURS MIN.			s. BIRTHPLACE Country)	E (State of Foreign	
	. 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give :  Levindale H RESIDENCE OF DECEDENT				or Location of D	EATH	9c. COUN	9c. COUNTY OF DEATH		
	permit. Pages 1,	DIRECTOR	10e. STATE 10b. COUNT	Harford	arford 10c. CITY, TO					10d. INSIDE ( LIMITS?  1 \sum YES 2		
		FUNERAL	100. STREET AND NUMBER 2400 Shuresvil	le Road	Road			101. ZIP CODE 21034			COUNTRY?	
	the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D. WW	2 NO	13. WAS DE It yes, s 1 🖂 YE		usa or No-  14. RACE — American Indian, Black, White, atc.  Specify:  White				
21215-0 Il or attending	for use as	ETED.	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work done during most of working							
	be detached at once.	COMPLET	12 17. FATHER'S NAME (First, Middle, Lest)		Engine	ering Te	chnician		deral Gov	ernme	nt	
RYLA ed by the		BE C	Abraham	Hostetter		Mart	tha	Woodro	oodrow			
	e 5 should notified	5	Mrs. Frances C.	Hostetter				ington, N	034			
BALTIMORE, or death. Page 6 may be	tuneral director, page xaminer must be		20e. METHOD OF DISPOSITION  1 M Burlel 2 Cremetton 3 Rem 4 Donatton 5 Other (Specify)	noval from State Carr	netery, crematory or			DATE	20c. LOCATION — C			
TIM.	e tuneral dire. J. examiner n		21. SIGNATURE OF FUNERAL SERVICE LI		ariingto		AND ADDRESS OF FA		Darling		MD	
B 5	eo = : eo [		William ?	X Xm		Havr	<u>e</u> de Gra	ace, M	ral Home, D 21078	-3197		
50, within fours	completely filled in by the ial, cremation, or remova sevent, the medical		23. PART I. Enter the diseases, or ehock, or heert feilure.  iMMEDIATE CAUSE (Final disease or condition reaulting in death)	List only one ceuse on e	the deeth. Do ach line.	Q DF):			or reapiratory arre		Approximate Interval Batween Onset and Dasth	
P.O. BOX 68 ath certificate be execu	ending physician and ci Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially flat conditions, if any, tauding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. ONE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.									
RDS	and and	MEDICAL O		na contributing to death b	ontributing to death but not resulting in the under $\sum_{i=1}^{n} c_{i}$				WAS AN AUTOPSY PERFORMED? YES 2 HO	AVAIL/ COMP OF DE	AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO	
AL B			DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O		ES NO [		Ν□				
F =	the State [	PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	me 5 Residence	8 Other (Spi	ocify)			
OF PHYSIC	with with	ву РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TH	JURY W	JURY AT PORK? YES 2 NO	28d. DEŞCRIB	28d. DEŞCRIBE HOW INJURY OCCURED			
DIVISION OR ATTENDING	after d		3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, factory, off	281. LOCATION City or You	OCATION (Street and Number or Rural Route Number, City or Town, State)				
DIN SPITAL OR	42=	COMPLETED	one) —	ICIAN: To the best of my know ER: On the basis of examination							menner es stated.	
TO THE HOSPITAL	TO THE FUNERAL DE filed within 72 IMPORTANT: If	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	MD.	-		29c. LICENSE NU	MBER 3/7	29d. DATE ►JU	SIGNED (Month	7,00y, Year)	
		-	SUNK P RAT	O COMPLETED CAUSE OF DE	2734 2434	W B	elver	deni	Are	- 21	215	
	- 1	1	31. DATE FILED (Month, Day, Year)	32 REGISTRANIA SIGN	AMERICA AN							

JUN 0 5 1995

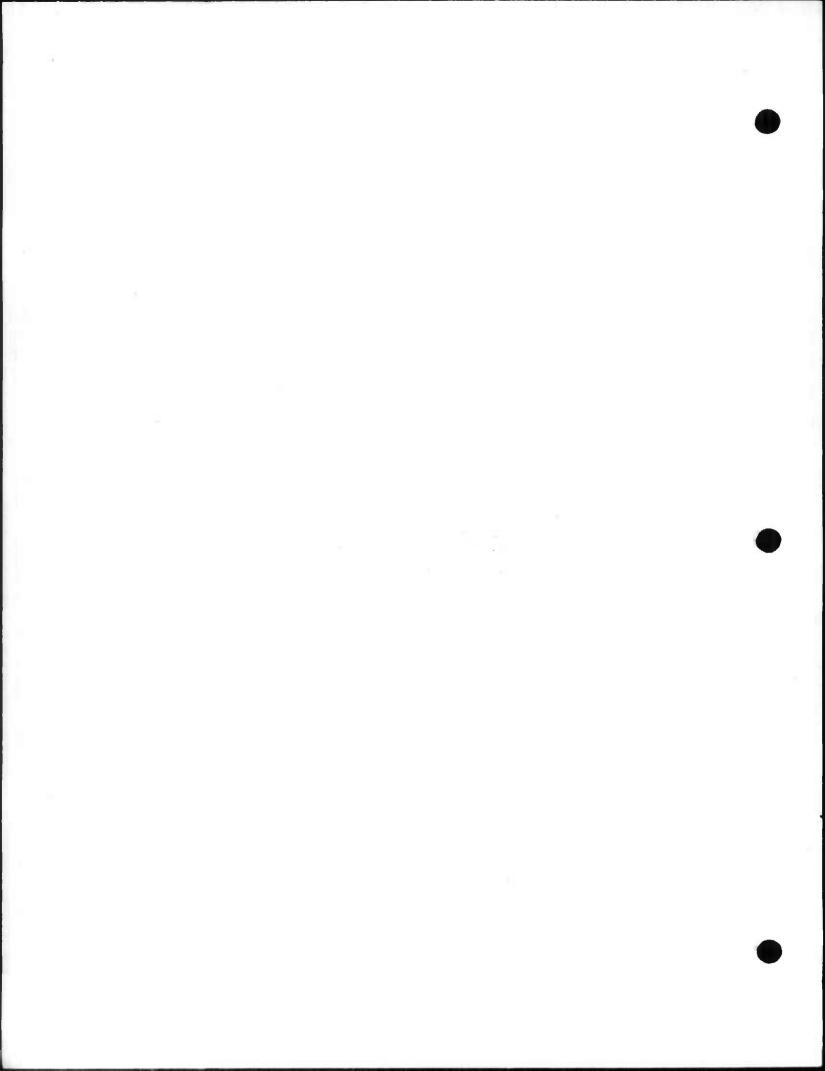
An in ease in the second

		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / D	EPARTMEN RTIFICAT	T OF I	EALTH AND DEATH	MENT	AL HYGIEN	E		
	1	1. DECEDENT'S NAME (First, Middle, Last)	ooks					MON	m 38	95	YEAR 3.	TIME OF DEATH
shouid	1	4. SOCIAL SECURITY NUMBER  417-36-1365  9e. FACILITY NAME (If not institution, give	1 □ M 2 🕌 F	(In yrs. lest b	YRS. MONTHS	DAYS	F UNDER 24 HRS. HOURS MIN.	M	e of Birth nth, Day, Year) arch 7	,29	Ala	ACE (State or Foreign
1, 2, 3 sho	TOR	Harford Men	ional Hasp	Hal	1 1		or location of the		,	Sc. COUNT	TOP DEAT	D C
permit. Pages	DIRECTOR		v ford		Aberd		TION					Dd. INSIDE CITY LIMITS?  XYES 2 NO
. usit	FUNERAL	314 Third Stre					21001			USA		AT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	ETED BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR DO	2 X NO	13.	If yes, sp		can, Puerto Rican, etc.)  Black, Specify:				American Indian, White, etc.
21 for u		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give Ille, Do	DENT'S USUAL OF kind of work done o NOT use retired.)	during mo	ON est of working	16b. KIND OF BUSINESS/INDUSTRY				
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Last) Ell Kelly		18. MOTNER'S N		Middle, Meiden : Fikes						
	TO B	19a. INFORMANT'S NAME (Type/Print) William Hooks						tural Route Number, City or Town, State, Zip Code)  Aberdeen, MD 21001				
IORE, e 6 may be ector, page must be r		20a. METHOD OF DISPOSITION 1 © Buriel 2 □ Cremetion 3 □ Rem 4 □ Donetion 5 □ Other (Specify) □	oval from Stata UT	PLACEAND	DATE OF DISPO	SITION /No		DA	TF 20c. LOC	ATION — CI	ty or Town	State
death. Pag e funeral dir e.		21. SIGNATURE OF FUNERAL, SEMICE M		1		NAME AI Bea	ard Fun Lewis	era.	l Home		_	
wittin 24 hours aft pipetesty filled in by cremation, or remorement, the medical cent, the medical		23. PART I. Enter the disease, or ahock, or haart fallure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused List only one cause on e	ach lina.	rego	the mo	da of dying, au	ch aa ca	rdiac or reaple	etory arre	at,	Approximata interval Between Onset and Death
P.O. BOX 68 through certificate be executed in Hygiene prior to bur or other traumatife.	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST										
L RECORDS, F law requires that the death as been signed by the atten bept. of Health and Mental 23 shows any injury, or	MEDICAL C	PART II. Other significant condition	11/1/1	le le	471	nderfyin	g cause given in	Part I.	24s. VALS AN A PERFORM 1 TYES 2	MED?	OF	ERE AUTOPSY FINDHOUS RILABLE PRIOR TO IMPLETION OF CAUSE F DEATHS
	SICIAN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		-	YES DEATH (Check		UNCERTAI	N 🗆			1	□ YES 2 □ NO
CIAN: ertification the St	PHYSIC	1 TYES 2 NO	HOSPITAL: 1 ☐ inpetient 2 ☐ ER/Outp  28s. DATE OF SKAJWY		6b. TIME OF	aing Hom 28c. (NJ		-		JURY OCCU	men	
ONG DIING After death	TED BY P	Netural 5 Pending Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home,	296. TIME OF 286. INJURY AT WORKT T YES 2 NO At home, farm, street, factory, office				28f. DESCRIBE HOW INJUSTY OCCURED  28f. LOCATION (Street and Number or Flural Floute Number, City or Thert. State)			
DI AL ORRI 2 hour f item	COMPLET	29a. CERTIFIER (Check only	CIAN: To the best of my knowl									nd manner se steted
TO THE HOSPITA TO THE FUNERA DE filed within 7. IMPORTANT: I	BE	296. SIGNATURE AND TITLE OF CERTIFIE	Ma less	1/11-	Mo		29c. LICENSE NU	IMBER   LL	91	29d. DATE		
	01	30. NAME AND ADDRESS OF PERSON WHO AND ADDRESS OF PERSON WHO AND ADDRESS OF PERSON WHO A	O COMPLETED CAUSE OF DEA	ATH (ITEM 2	N (Type, Prigray)	40	75-	V	1 con	wa (	four	5 de gree

32. BEGISTHAR'S SIGNATURE
Julia Dawelson Randall

31. DATE FILED (Month, Day, Year)

JUN 0 2 1995



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 m. Jurs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

HUL

1 1995

FOR 1 . STATE		STATE OF N	IARYLAND	/ DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGI	ENE		1 0 0 000	
REGISTRAR  1. DECEDENT'S NAME (First,	Middle, Last)		RISON	ERTIF	CATE OF	DEATH	REG. 1	NO.	YEAR	3. TIME OF DEAT	Н
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In vrs.	last hirthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	MAY 28	199		16:15	Рм
218-34-93		1 💢 M 2 🗆 F	56	YRS.	MONTHS DAYS	HOURS MM.	7. DATE OF BIRTH (Month, Day, Year Aug. 9 1	938	Mary	yland	reign
30470 Pine K	(noll D					or location of d	EATH		of D Omers		
RESIDENCE OF DEC	10b. COUNTY			400 CITY	TOWN OR LOCAL				JIIIOL		
Maryland	Some	rset			al Isla	nd				10d. INSIDE CITY LIMITS? 1 (X) YES 2	
23311 East S	Chool	Dood			101	. ZIP CODE		10g. CIT		WHAT COUNTRY?	
11. MARITAL STATUS		12. WAS DECEDENT	FVER IN U.S.	ARMED	12 WAS DEC	21821	NIC ORIGIN? (Specify		U.S.		
1 Never Married 2 3 Widowed 4 M Divo	Married	FORCES? 1	YES 2		It yes, sp	ecity Cuban, Maxica 2 NO Specif	an, Puerto Rican, etc.)	Yea or No-	14. RACE Black Specif	American India k, whita, etc.	n,
15. DECI (Specify only	EDENT'S EDUCA highest grade of	ATION ompleted)		(Give kind of w	USUAL OCCUPATION done during mo	ON of working	16b. KIND OF	BUSINESS/INC	DUSTRY	**************************************	
Elementary/Secondary (0		College (1-4 or 5+)		Salesm	retired.)	St Of WORKING	Trans	portat	rion		
17. FATHER'S NAME (First, Mi	ddle, Last)					18. MOTHER'S NA	ME (First, Middle, Maid		TOIL		
Calton Har						Truss	ell Webst	er			
19e. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS (Street a		Route Number, City or		Code)		
Trussell W.		son					ad. Deal			21821	
20a. METHOD OF DISPOSITION  1  Burial 2  Cremation  4  Donation 6  Other	n 3 🗆 Remov (Specify)	2555		rematory or oth	FDISPOSITION (Na	eterv	DATE 20c.	LOCATION -	City or Tox	wn, State	
21. SIGNATURE OF FUNERAL	SERVICE LICE	NSEE	1 00	0011110	22. NAME AN	D ADDRESS OF FA	CILITY	691 12	Tallo	I MO	
* James	2.16	in a	M00295	5		an Funer	al Home e. Md. 21	OEO			
23. PAST Enter the dis	saesea, pr co	mplications that ist only one caus	caused the c	leeth Do nr	ot enter tha mo	da of dying, suc	h as cardiac or rea	ous apiratory arr	eat,	Approxima	te
immediate CAUSE (Findings as or condition resulting in death)	rait laiture. Li	ast only one caus	C A+	ne. ncar	OF.	The	Da in	2000		Interval Ba Onset and	tween
and the second of the second		DUE TO (	OR AS A CONS	EOUENCE OF	:	7	P	ACCES	1		
Sequentielly list condition if any, leading to immedicause. Enter UNDERLY()	late	DUE TO (	Met OR AS A CONSI	asty Equence of	TIL	CANUER	. Sprea	d in	1;1	er	
CAUSE (Disease or injur that initiated events resulting in death) LAST	у 🔓 с	DUE TO (	OR AS A CONSI	EOUENCE OF)	:			·			
PART II Other simplifican	d.										
PART II. Other significer	CONTRIBUTE	CONTRIBUTING TO 0	lesth but not	reautting in	the underlying	cause given in	Part I. 24a. WAS PERF	AN AUTOPSY ORMED?		WERE AUTOPSY FIN AMILABLE PRIOR TO COMPLETION OF CA OF DEATH?  1 YES 2 NO	O NUSE
25. WAS CASE REFERRED TO	MEDICAL				26. PL	ACE OF DEATH Ch	ack only one)				
1 YES 2 NO		HOSPITAL:	ER/Outpatient		OTHER:		6 Other (Specify)				
27. MANNER OF DEATH		26a. DATE OF II	NJURY	26b. TIME	OF 26c. INJU	JRY AT	26d. DESCRIBE HOV	Y INJURY OCC	URFD		
1 Netural 5 P	ending westigation	(Month, Day	( 10 <i>ar</i> )	INJU		RK? ES 2 NO					
3 Suicide 6 C	ould not be etermined	28e. PLACE OF building, at	INJURY At h	ome, farm, etc	set, factory, office		281. LOCATION (Stree City or Town, Sta	et and Number to)	or Rural Ro	oute Number,	
29a. CERTIFIER	EVING PHYSICIA	AN: To the heat of a		0							
(Check only one) 2 MEDIC	AL EXAMINER:	On the basis of exa	ry knowledge, d minstion end/or	Investigation	at the time, date	and place, and due	to the cause(s) and m time, deta and place,	nanner aa state	id.		
29b. SIGNATURE AND TITLE (					at my opinion, be			end due to the	· cause(a)	end manner as sta	ted.
Catheri	e 6	9. No	the !	no		29c. LICENSE NUN	6128	29d. DATE	SIGNED	(Month, Day, Year)	
a NAME AND ADDRESS OF	A. Nor	th m	D B	OX 41	5 PF	RMC.	Salish	CIPV.	Me	1 2180	
31. DATE FILED (Month, Day, Ye	4 400	32. REGISTRAR	SISIGNATURE	Robert				/			

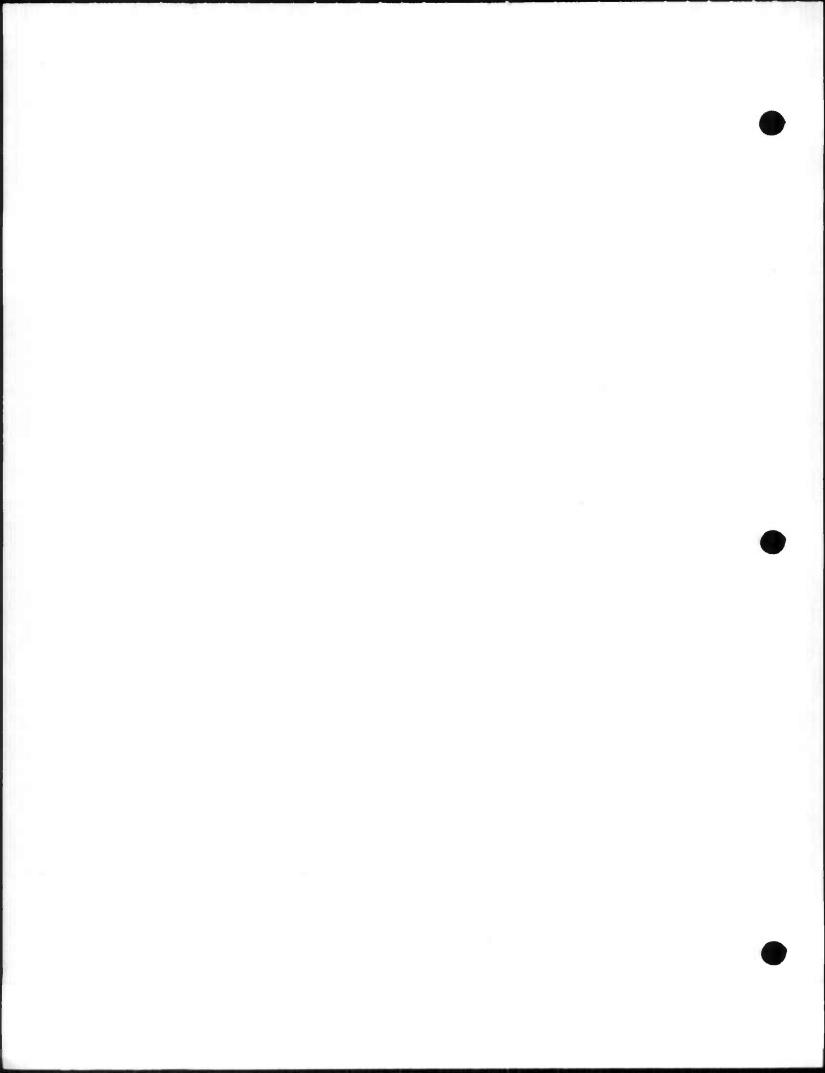
JUN 1 1995 John Stanbardschaft

BALTIMORE, MARYLAND 21215-0020

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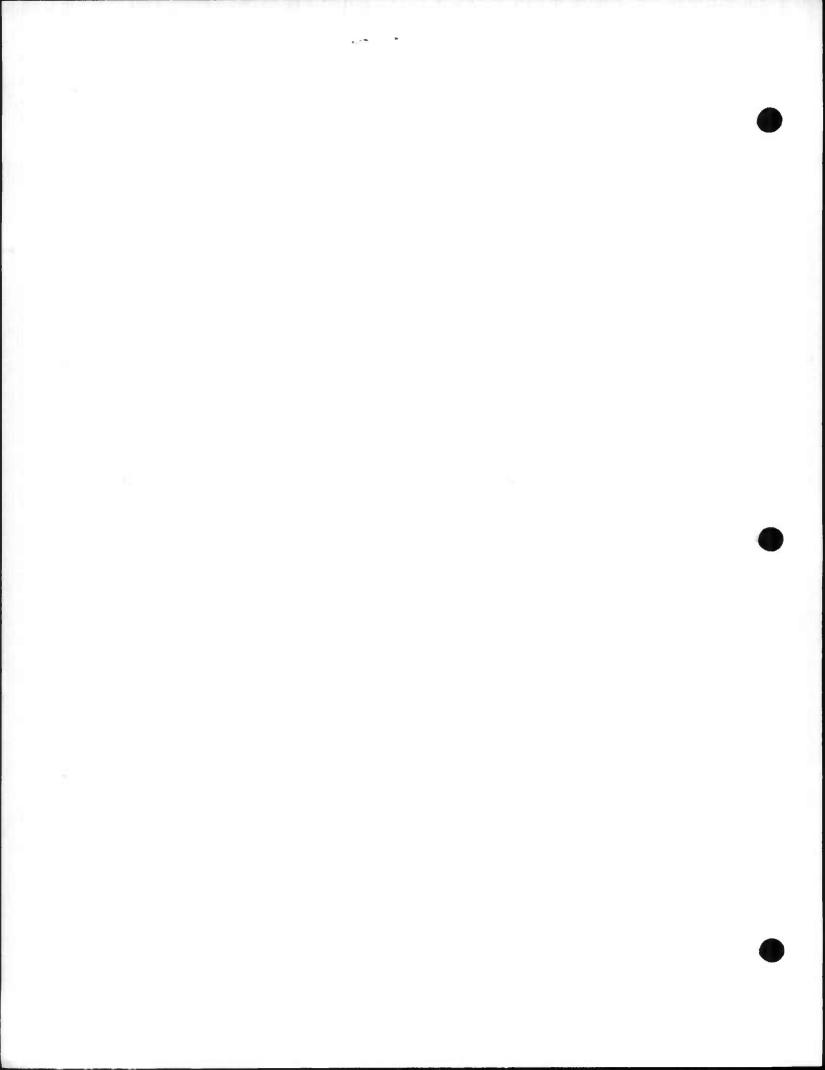
NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	1. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should reach with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
) THE HOSPITAL DR ATTENDING PHYSICIAN: The	THE FUNERAL DIRECTOR: After this certificate the filed within 72 hours after death with the State in	APORTANT: If item 28 is marked, or item

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	ROLD :	T HE	ELMS		2. DATE OF OEATH MONTH D	7H 1995	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER  246-12-1722  98. FACILITY NAME (If not institution, give str	1 M 2 🗆 F	n yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct 20 19	Cour	N.C.			
TOR	Good Samaritan Ho				ltimore	EATH	9c. COUNTY OF	DEATH			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAL Baltim				10d. INSIDE CITY LIMITS?  Y YES 2 NO			
FUNERAL	3209 Pelham Ave			101	21213			WHAT COUNTRY?  J.S.A.			
B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced	U.S. ARMED 2 NO ATES	If yes, sp		NIC ORIGIN? (Specify Ye in, Puerto Rican, etc.) y:	CE — American Indian, ck, White, atc.  City:  White					
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed)  College (1-4 or 5+)	me. Do NOT use	ork done during mo retired.)	st of working	16b. KIND OF BU					
WO	17. FATHER'S NAME (First, Middle, Last)		rillar N	depairma.		AUCO IV	lanufactu	iring			
BEC	Joseph		Helms			nces		rowood			
စ္	190. INFORMANT'S NAME (Type/Print)  Carolyn Distler					Route Number, City or Tow					
	20a. METHOD OF DISPOSITION	200		Howes R		kirk, MD	20754				
	20b. PLACE AND DATE OF DISPOSITION   DATE   1   Buriel 2 1 Cremetion 3   Removet from State   4   Donation 5   Other (Specify)										
	21. SIGNATURE OF UMERAL SERVICE LICE	1/1		22. NAME AN	n Funera	l Home, PA	Owings	, MD 20736			
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplication that caused list only one cause on ea	the deeth. Do no	ot enter the mo	da of dying, suc	h as cardiec or reap	iratory arrest,	Approximata Interval Batween			
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	150	TEMIC CONSEQUENCE OF		EL			Onset and Death 5 DAYS			
z	6 b	SE	PSIS	):				12 DAY			
ICATIC	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	U		LE AI	UGINA		12 DAYS				
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):  RESPIRATORY FAILURE  121									
₹∥	PART II. Other algnificent conditions	contributing to deeth be	it not resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN PERFOR	PMED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IRUTE TO CAUSE O	F DEATH YES	NO [	UNCERTAII			YES 2   NO			
CA	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH	(Check only one)	UNCERIAII						
IX SI		1 Inpetient 2 ER/Outp	itlent 3 DOA			8 Other (Specify)					
BY P	Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY WO	JRY AT RK? ES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCURED				
ETED B	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, term, st	me, term, street, factory, offica		281. LOCATION (Street of City or Town, State)	and Number or Rural	Route Number,			
COMPLE		IAN: To the best of my knowle : On the basic of examination						e) and manner sa stated.			
O BE	29b. SIGNATURE AND TITLE OF CERTIFIER	M.D	) ,	P-O	7668	29d. DATE SIGNED	E STH 1995				
		IPPIM MD	900D SI	AMARIT	AN HOS	SPITAL BY	ALTIMO	RE MD 212399			
	JUN - 6 1995	32 REGISTRAR'S SIGNA	Rarball								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Derr of Health and Mental Houlene prior to having companion or semonal.
is marke

	1 - FOR REGISTRAR	STATE OF MA	ARYLAND C	/ DEPAR	TMENTICATI	OF H	IEALTH DEA	AND I	MENT	AL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	90	HI	4YDE	N				MON	1AY 3	AY O	YEAR 95	3. TIME OF CEATN
		5. SEX 1 💢 № 2 🗍 #	yrs.	MONTHS DAVE			MIN.	Marth, Day, Yani) JULY 17,		1913	1913 Maryland		
œ	9e. FACILITY NAME (If not institution, give stre		-1 Com				OR LOCATI	ON OF D				NTY OF D	EATN
DIRECTOR	Southern Maryland	d Hospita	ar cent			into					PEL	nce (	George's
DIRE	Maryland Prine	ce George	e's	10c. CITY, TOWN OR LOCATION Suitland									10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER 2614 Fort Drive				101	ZIP COD 2074				THAT COUNTRY?			
Y FUNERAL	1 Never Married 2 Married	EVER IN U.S. A YES 2	RMEO NO		WAS OEC	ENDENT (	OF NISPAI	an, Puerto	IN? (Specify Yes	- American Indian, White, atc.			
D BY	3 Widowed 4 Divorced  15. DECEOENT'S EDUCA	TION	16a. D	ECEDENT'S	USUAL O	CCUPATIO	NA .			b. KIND OF BU	DIMEGO/ILM		lite
(Specify only highest grade completed)  (Give kind of work done during most of working life. Do NOT use retired.)  (Give kind of work done during most of working life. Do NOT use retired.)													13,
OMP	12 17. FATHER'S NAME (First, Middle, Last)		Baı	rtend	er		16. MOT	NER'S NA		Middle, Meiden		nd Ba	ar
BE C	Maurice Dutton H	ayden								lia Sim	,		
19e. INFORMANT'S NAME (Type/Print)  19b. MAILINO ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Cod										Code)	ode)		
	Verna Hayden  2614 Fort Drive, Suitland, Md 20746  20g. METHOD OF DISPOSITION 1 K Burlel 2 Cremetton 3 Removel from State 4 Denatton 5 Other (Specify)  2614 Fort Drive, Suitland, Md 20746  20b. PLACE AND DATE OF DISPOSITION (Name of June 3, 1895) 20c. LOCATION - City or Town, State Washington Thational Cem.  Suitland, Maryland												
	4 Donation 5 Other (Specify)	n wa	tion	al C	em.		Sui	tlan	d, Ma	aryland			
	21. SIGNATURE OF FUNERAL SERVICE LICE!  Malan Jan B.		0	ld A	lexa	nder	Fe	cry Roa	id, C	linto	e,Inc 6633 on,Md 20735		
	23. PART I. Enter the diseases, or co- ahock, or heart failure. Li-	mplications that only one cause	ceused the d	eath. Do r e.	not enter	the mo	de of dy	ing, auc	h as ca	rdiac or reap	iratory an	reat,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Ventre	culor	av	ryl	tin	red	W	nta	Card	uc	an	Col Snen
z	OUE TO (OR AS A CONSEQUENCE OF): O Cutenisacles to Heart Lisease 22 us;												
ATIC	the any, leading to immediate cause. Enter UNDERLYING												
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	Mela	H AS A COUSE	OUENCE D	lu	nd	T	na	es	00			14 wk
IL CE	PART II. Other aignificant conditions	contributing to d	eath but not	resulting	in the ur	derlying	cause	given in	Part i.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICA	Osteoclastic	Carci			Ry	al	· K	do	ey	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAU	SE OF DEA	ATH YE	s XI	NO [	UNC	ERTAIN	N 🗆				1 YES 2 NO
PHYSICIAN:		OSPITAL:		CE OF DEAT	OTHER	1:							
H.	27. MANNER OF DEATN	28a. DATE OF IN (Month, Day,	JURY	28b. TIM	-	28c. INJ		sidenca		er (Specify) SCRIBE HOW I	NJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation		703		M	1 🗆 1	ES 2	] NO					
TED	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	c. (Specify)	ome, farm, s	Hreet, fact	ory, office			281. LO C/h	CATION (Street in or Town, State)	and Number	or Runel Re	oute Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIA MEDICAL EXAMINER:												and menner as stated.
BE C	296, SIGNATURE AND TITLE OF CERTIFIER	110	)_				29c. LICE	NSE NUN	MBER	-7	29d. DAT	E SIGNED	(Month, Opp. Year)
2	36 NAME AND ADDRESS OF PERSON MUD	COMPLETED CAUSE	OF OEATH (ITE	M 27) (Type,		,	-1	0 /	1	( )			
	31. DATE FILEO (MODITY, DEV. YEAR)	32. REGISTRAR	S SIGNATURE	1418	40	IN9	Ston	R	d	Fort	WA	Sh, I	md, 20744
	JUN 0 6 1995	Julia d	Audior A	ardall									



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DIVISION OF VITAL RECORDS, P.O. BOX 68

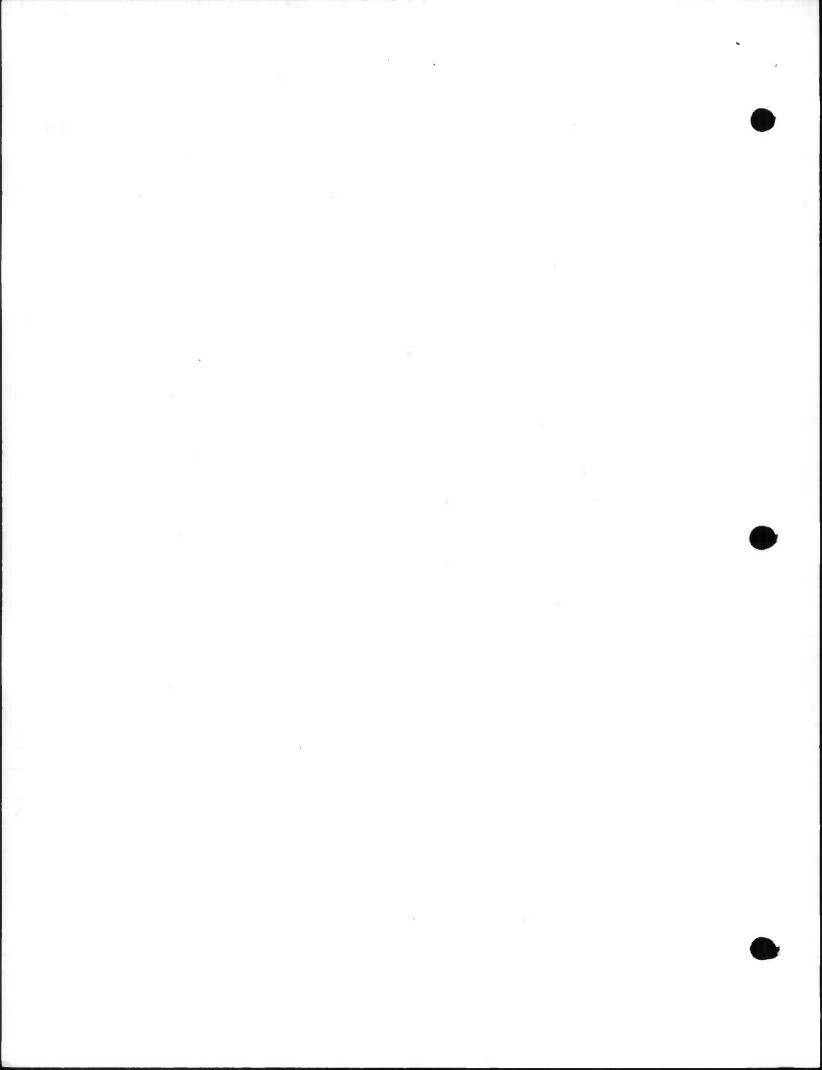
TO THE HOSPITAL OR ATTENDIN TO THE FUNERAL DIRECTOR: Afr be filed within 72 hours after dea IMPORTANT: It item 28 is m

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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PHYSICIAN: The law requires that the death certificate be executed within minours after death. Page 6 may be retained by the hospital or attend	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Dept, of Health and Memal Hydiene prior to burial, cremation, or remonal.	s marked, or Item 23 shows any Injury or other traumatic event, the medical avainings must be notified at nace
De	ate Date	E
AN	tifica e St	7r 18
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TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI				YGIENE EG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D		T	3. TIME OF DEATH		
John Joseph Ha	auswirth				монтн 5	31	95	8:25 A M		
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH	a. BIRTH	PLACE (State or Foreign		
027-14-6801	1 🕅 M 2 🗌 F	67 YRS.	ONTHS DAYS	HOURS MIN.	2/16		Country) M.A			
9e. FACILITY NAME (If not institution, give stre	set end number)	9	b. CITY, TOWN	OR LOCATION OF DI						
13321 Ocean Dr.			Ocea	n City		Wor	cest	er		
RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		1				1 1101	CCSC			
	_	10c. C(14, 1	TOWN OR LOCA				1	10d, INSIDE CITY LIMITS?		
MD WO	rcester		Ocean					t TYES 2 NO		
			10	ZIP CODE		10g. CITI		HAT COUNTRY?		
13321 Ocean Dr	12. WAS DECEDENT EVER I		I	21842				SA		
1 Never Merried 2 Married	FORCES? 1 XYES	2 NO	It yes, sp	ENDENT OF HISPAI ecify Cuban, Maxica	in, Puerto Rican,	etc.)	14. RACE Black	- American Indian, White, etc.		
3 Widowed 4 Divorced	WW II	ATES	1 TYES	2 XNO Specif	y:		Specif	white		
15. OECEDENT'S EDUCA	ATION	16a. DECEDENT'S US	UAL OCCUPATION	ON .	16b. KIND	OF BUSINESS/IND	USTRY	Wille		
(Specify only highest grade of Elementary/Secondary (0-12)	Ompleted)  Cotlege (1-4 or 5+)	(Give kind of work life. Do NOT use n	k done during mo	st of working	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
12		Pressr	man		1 119	Govern	men	+		
17. FATHER'S NAME (First, Middle, Last)		110331	narr	18. MOTHER'S NA		Malden Sumerne)	men			
John Joseph Ha	uswirth			Cathe	erine H	aves				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AC	DORESS (Street e	and Number or Rural			Code)			
Wilma Hauswirth				n Dr. O			218	42		
20e. METHOD OF DISPOSITION		. PLACE AND DATE OF	DISPOSITION (Ne			20c. LOCATION —	-			
1 Burial 2 Cremation 3 Removed 4 Donation 5 Other (Specify)	rel from State	ape Henlo	plece)	rematory	5/31/0	5 Frank	ford	DE		
4 Donation 5 Other (Specify) Cape Henlopen Crematory 5/31/95 Frankford, DE 21. SIGNATURE OF SHERRY SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY										
V Neker	2		100	1111111	Bu	rbage Fu	uner	al Home		
23 BADT I Street diseased or so	Instala		108	Williams	St. B	erlin, M	D 21	811		
23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. Liet only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition	LUNG							Onset and Death		
resulting in deeth)			RR							
	DUE TO (OR AS	CONSEQUENCE OF):								
Sequentielly liet conditions, b.	DUE TO 100 100						_			
if any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								
CAUSE (Disease or injury C.	DUE TO (OD AS )	COMPEQUENCE OF								
that initieted events resulting in death) LAST	DOE TO (OH AS A	CONSEQUENCE OF):								
d.										
PART II. Other significent conditione	contributing to death b	ut not resulting in I	the underlying	g ceuse given in	Part I. 24a.	WAS AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
						YES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
					'''	TES 2 DO NO		OF OEATH?		
DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	Пиог	UNCERTAIN				1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEATH		OTTERIAL	, ,					
	HOSPITAL:		THER:	• 5 KResidence	A Chartes	-4.1				
27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O				HOW INJURY OCC	HIBED			
Natural 5 Pending	(Month, Day, Year)	INJUR	Y WO	RK? (ES 2 NO						
2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	- At home, farm, stre-			281, LOCATION	(Street and Number	or Bural Br	rute Number		
4 Homicide detarmined	building, etc. (Spec	cify)	•		City or Tow					
290. CERTIFIER	AN. To the heart of a state			DE SECONO		0. 7/ 5-10-0				
	AN: To the best of my know							estable messessi		
2 MEDICAL EXAMINER:	THE DESIGN OF STREETINGSTO	cruior investigation, I	in my opinion, d	eem occured at the	time, date end p	race, and due to the	e ceuse(s)	and menner as stated.		
296. SIGNATURE AND TITLS OF CENTIPIER				29c. LICENSE NUM	BER	29d. DATE	SIGNED	(Month, Day, Year)		
1 my 1 society	/			1248	12	P 3	13/	195		
60. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OE	6//		. /			,			
31. DATE FILED (Month, Day, Year)	UR.	Sallsbui	rey 1	ud	2/80	/				
	32 MEGISTRAR'S SIGN									



l or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

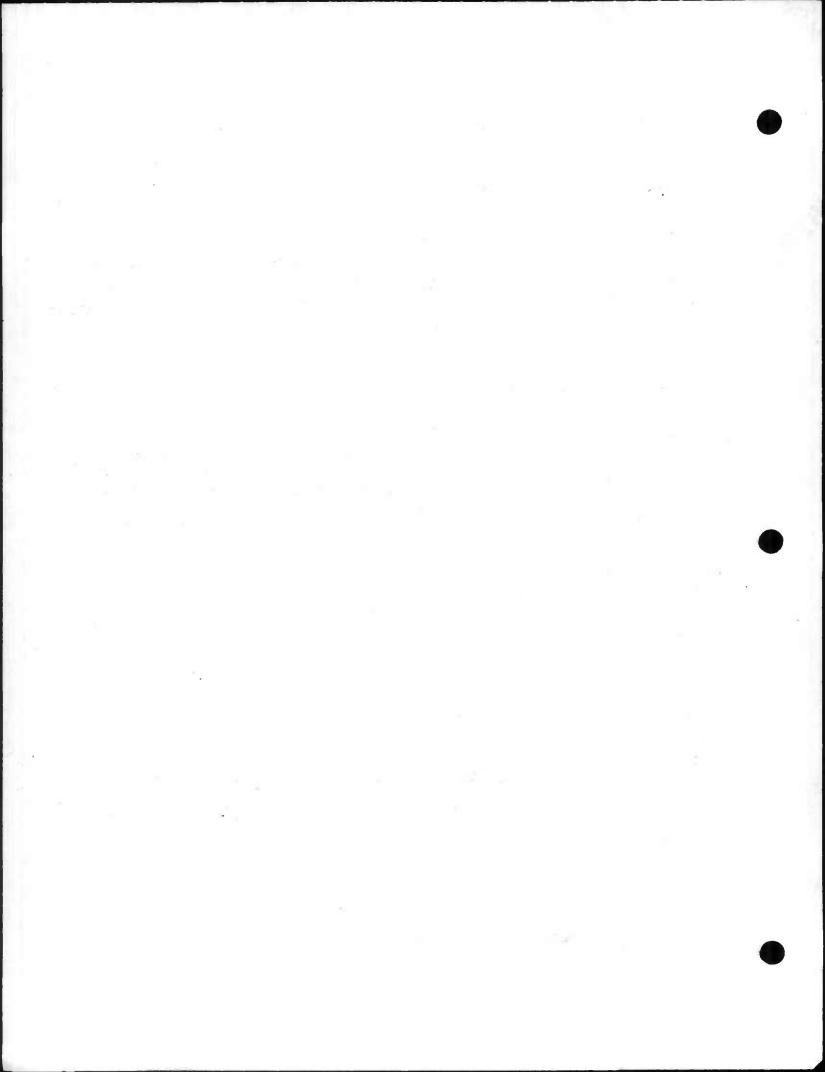
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executed within 24 hours after death. Page 6 may be retained by the hospir	det	
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E	JOR: After this certificate has been signed by the attending physician and completely filled in by the fur	afte

STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	ID MENTAL HYGIENE
CERTIFICATE OF DEATH	PEG NO

FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMENT OF H CERTIFICATE OF		NTAL HYGIENE REG. NO.	
1. DECEDENT'S NAME (First	, Middle, Last)  Kathleen Hawes  BER S. SEX 6. AGE (in yr		2.	DATE OF DEATH	9 3. TIME OF DEATH
2/8 - 24 - 7 90. FACILITY NAME (# not in	54/1□M2 ØF		OR LOCATION OF DEATH	DATE OF BIRTH (Month, Day, Year) 0/06/26	8. BIRTHPLACE (State or Foreign Country)  ARROWS URG ME  COUNTY OF DEATH
RESIDENCE OF DEC	10b. COUNTY	Freder			Frederick  10d. INSIDE CITY
	Frederick	Brunsu	L ZIP CODE	10g.	LIMITS?  1 Z YES 2 NO  CITIZEN OF WHAT COUNTRY?
10. STREET AND NUMBER  825 Secon  11. MARITAL STATUS  1 Never Merried 2 3  3 Widowed 4 Divo	Married 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	NO If yes, sp	2/7/6 CENDENT OF HISPANIC ( Decify Cuban, Maxican, P 3 2 (X) NO Specify:	ORIGIN? (Specify Yea or No uerto Rican, atc.)	Black, White, atc.
Specify onl	EDENT'S EDUCATION y highest grade completed)  160  161  162	a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during molifie. Do NOT use retired.)	ost of working	16b. KIND OF BUSINESS	White B/INDUSTRY
12 17. FATHER'S NAME (First, M ALV in Mil	liddle, Last)	etired sea	18. MOTHER'S NAME	H.L. Ha (First, Middle, Malden Surman Staubs M	ne)
19a, INFORMANT'S NAME (1)  9 ohn L. #  20a, METHOD OF DISPOSIT	awes	19b. MAILING ADDRESS (Street & 825 Second ACE AND DATE OF DISPOSITION (No.	Avenue,	Brunswick	n, Zip Code) , MD 21716  N — City or Town, State
	on 3   Removal from State (Specify)   R (	y, crematory or other place)  DWN1VILLE He  23 NAME AI  JONN	ights Ce	metery Br Lams Fune	ownsville MD
23. PART I. Enter tha d shock, or h iMMEDIATE CAUSE (Fir disease or condition resulting in death)  Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuited initiated events resulting in death) LAS	DUE TO (OR AS A CO	a dasth. Do not antar the mollina.  NSEQUENCE OF:	de of dying, such a	a cardiac or respiratory	Approximata Interval Between Onset and Death
that initiated events resulting in death) LAS	T d.				
WEDICK	int conditions contributing to death but r	not resulting in the underlying	g cause given in Par	1   24a. WAS AN AUTOF PERFORMEO? 1   YES 2   NO	AWAILABLE PRIOR TO
25. WAS CASE REFERRED TEXAMINER?	O MEDICAL  HOSPITAL: 1   Inpetient 2   ER/Outpatie	OTHER:	LACE OF DEATH (Check		
	Pending (Month, Day, Year)	26b. TIME OF 28c. INJ		d. DESCRIBE HOW INJURY	OCCURED
3 Suicide 6	Could not be detarmined 28e. PLACE OF INJURY — building, stc. (Specify)	At home, farm, street, factory, offic	26	f. LOCATION (Street and Nur City or Town, State)	mber or Rural Route Number,
(Check only	TIFYING PHYSICIAN: To the best of my knowledge ICAL EXAMINER: On the best of examination and				
296. SIGNATURE AND TITLE	Li Myain	40	29c. LICRUSE NUMBER	75 29d.	DATE SIONED (Month, Day, Year)
30. NAME AND ADDRESS OF		Browsu	nce t	10 21	716
31. DATE FILED (Month, Day,	0 7 1995 32. REGISTRAR'S SIGNATUR	or Reveally			

BALTIMORE MARYI AND 21215-0020 DIVISION OF VITAL RECORDS. P.O. BOX 68760 1 - STATE

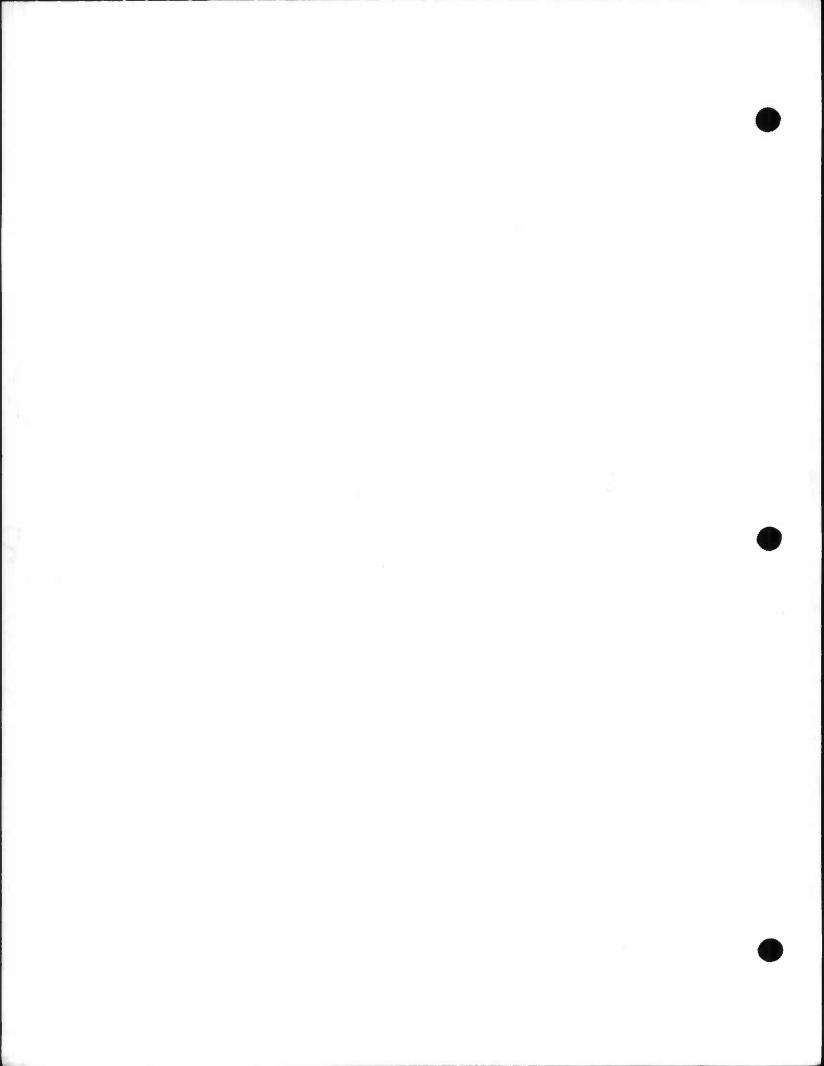
	REGISTRAR		C	ERITH	CATE	OF D	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Leet)	113 T T						2. DATE OF DEATH MONTH JUNE	N 2	995	TIME OF DEATH
	CAROLYN P								5, I		0005 Am
	220-42-5441	1 M 2 N F	AGE (In yrs. lac 49		IF UNDER 1 Y		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Wear) June 26,	1945	a. BIRTHPL Country) Penns	ACE (State or Foreign ylvania
	8e. FACILITY NAME (If not inetitution, give-	street end number)			96. CITY, TO	NO NWC	LOCATION OF DE			INTY OF DEA	
DIRECTOR	FREDERICK MEMO	RIAL HOSP	ITAL	E.R.	FRE	EDEF	RICK		FR	EDER	CK
Ä	10e. STATE 10b. COUNT	Υ		10c. CITY	TOWN OR I	LOCATIO	N			10	d. INSIDE CITY
	Maryland I	Frederick		M	t. Ai						LIMITS?
FUNERAL	13932-A Prospect					101. 2	21771			Lted S	tates
BY FUI	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, OIVE WAR O		MED NO	13. WAI	S DECEN es, specif YES X	DENT OF HISPAN ty Cuben, Mexicas NO Specify	IIC ORIOIN? (Specify Yee n, Puerto Rican, etc.)	or No—	14. RACE — Black, V Specify:	American Indian, White, etc.
3	15. DECEDENT'S EDU	ICATION	16a, DE	CEDENT'S L	JSUAL OCCU	JPATION		16b, KIND OF BUS	LINESS/INI	DUSTRY	Black
COMPLET	(Specify only highest grade Elementary/Secondary (0-12)		(G	ive kind of wi Do NOT use	ork done duri	ng most o	of working	TOOL KIND OF BOX	PHACOO / HAI	DOGINI	
7	Exemple (0-12)	College (1-4 or 5+)	C.	lerk				Insura	nce		
5	17. FATHER'S NAME (First, Middle, Last)						A MOTHER'S NA	ME (First, Middle, Meiden			
	Kersey A. Jones	Sr				Ι.		. Knight	sumeme)		
N T	19a. INFORMANT'S NAME (Type/Print)	DI.	-								
2	Denise H. Brown		1"					Toute Number, City or Tow			. 701
								e Frederi			1701
	20a. METHOD OF DISPOSITION 14 Burlel 2 Cremetion 3 Rem	oval from State	cemetery, cre	AND DATE Of	FDISPOSITIO	ON (Name	of	DATE 20c. LO	CATION -	City or Town	, State
	4 Donetion 5 Other (Specify)		Frie	ndshij	o Uni	ted	Methodi	st 6/ <b>6</b> /95	Dan	nascus	, Maryland
	21. SIONATURE OF FUNERAL SERVICE U	CENSEE Q			22. NAI	ME AND	ADDRESS OF FAC	Stauffe	er Fu	neral	Homes, P.A
	Hammy K	aveg	8		162	1 Op	ossumto	wn Pike I	rede	rick.	MD 21702
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):										
E E	resulting in death) LAST	d			_						
EDICAL (	PART II. Other algolficant condition	ne contributing to deat	th but not r	eaulting in	the under	rlying c	ause given in i	Part I. 24e. WAS AN			ERE AUTOPSY FINDINGS
2								PERFOR		00	AILABLE PRIOR TO IMPLETION OF CAUSE
								110/ES 2	□ ₩0	Of	DEATH?
2	DID TOBACCO USE CONT	PIRLITE TO CAUSE	OF DEA	TH VE	T NO		UNCERTAIN			"	YES 2 NO
¥	26. WAS CASE REFERRED TO MEDICAL	I CAUSE			(Check only		UNCERIAIN	1 🗆			
ᄗ	EXAMINER? 1 ☑ YES 2 ☐ NO	HOSPITAL:			OTHER:						
PHYSICIAN: M	27. MANNER OF DEATH	1 Dipetient XXER/		28b. TIME				8 Other (Specify)			A LATING OF THE
	1 Natural 5 Pending	(Afonth, Day, Ye	95	INJU	RY	WORK	7 . /	DRALL OF			PROTHER WAR
B	2 Accident Investigation 3 Suicide & Could and be	280. PLACE OF INJ				office		281. LOCATION (Street o			
	4 Homicide 6 Could not be	building, etc. (	Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town, State)			
1	29e. CERTIFIER		RODD					KIHU FI			COMD
<u> </u>	(Check only 1 CEHTIFTINO PHYS	CIAN: To the beat of my k									
COMPLETED	MEDICAL EXAMINE	R: On the beele of examin	ation end/or i	nveatigation	, in my opini	ion, deati	h occured at the t	time, date end place, en	d due to th	ne cause(s) er	id menner se stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R Man	11.4.7	1			Oc. LICENSE NUM		29d. DAT	E SIONED (M	onth, Day, Year) 3, 1995
2	Mulline VIA	e viole	MW	/			O.C.M.I		PU	OINE 3	, 1993
	MARGANIA	D. LORE	111	Penr		eet	, Bali	timore, N	ary	land	21201
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAN'S S	HONATURE	2				- <u>i</u>			
	JUN 0 7 199!	) Jama alle	narrow (	artall							



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	Middle Last)										EG. NO.			
		,		4 _	36		7.73	T T 334				2. DATE OF I	DEATN	W	YEAR	3. TIME OF DEATN
		4. SOCIAL SECURITY NUMB	Els		May			LLAM				June 2	_	95		10:06 P. M
			EH	5. SEX	6. AGE (/			IF UNDER	1 YEAR	HOURS	24 HRS.	7. DATE OF B (Month, Day	HRTN y, Ybar)		8. BIRTN Countr	PLACE (State or Foreign y)
밀		77-26-8314		1 🗆 M 2 🗒	8	37	YRS.					Sept.	25,	1907		Maryland
plnods	-	9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF					NTY OF O	EATN	
eo.	DIRECTOR	Frederick	Memo	rial Hos	pita]	L			F	reder	ick				Fr	ederick
		10a. STATE	10b. COUNTY				100 CIT	Y, TOWN (	20.1.00	TION						
Page	<u> </u>	Maryland		ederick			100. 011	Fre								10d. INSIDE CITY LIMITS?
mit.		104. STREET AND NUMBER	11	CUCLICK				110								1 YES 2 NO
physician. burial-transit permit. Pages 1, 2,	FUNERAL								10	of. ZIP COD				10g. CITI		VHAT COUNTRY?
ian. trans	N N	2200 Roser	nont A								702				U.	S.A.
physician bunial-tra		1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	_ YES	2 X	O	13.	WAS DE	CENDENT Coperation	of HISPAN n, Maxica	iiC ORIGIN? (Sp n, Puerto Rican	pecify Yes i, etc.)	or No-	14. RACE Black	— American Indian, t, White, atc.
	B	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DA	TES			1   YE	S 2 NO	Specify	r:			Speci	<sup>₩</sup> White
al or attending for use as the		15. DEC	EDENT'S EDU	CATION		18a DEC	PEDENT'S	USUAL O	CCLIBAT	1001			2 22 244			
6 2	COMPLETED	(Specify only	highest grade	completed)		(Gh		work done		ost of working	g	TOD. KIN	D OF BUS	SINESS/IND	USINY	
spital ed fo	<u> </u>	Elementary/Secondary (0	-12)	College (1-4 or 5	''	_						77-		- 1		
the hospital detached fo	M	17. FATNER'S NAME (First, Mi	iddle Lest)	3		Re	gist	ered	nii		AFRIC MA	ME (First, Middle	pita			
by the hospit be detached at once.																
	BE	Harrison N.			_	100						e May				
5 should	일		William II			- 1						Poute Number, C				
y be		Ruth S. Wach							_		Fre	derick				
Jeath, Page 6 may be funeral director, page xaminer must be		1 ZBuriel 2 Crematio	n 3 🗆 Reme	oval from State		etery, cren	natory or o	OF DISPOS ther plece)				DATE		CATION —		
Page direc		21. SIGNATURE OF FUNERAL		ENSEF 0	Mt	_01	ivet	_Cem	ete	ND AODRES	Jun	d 7, 1	995	Fred	eric	k. Md.
death. Pag tuneral dia 1.		V,	10	- //	1	/		- 1					Func	227	Llomo	
0 = 0		Keeney and Basford Funeral Home  106 East Church St., Frederick,  23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,														
d in by the or removal		23. PART I. Enter the di	seases, or o	omplications the	t caused	the dea	nth. Do r	ot antar	the m	oda of dyi	ng, suci	as cardiac	or respli	ratory arr	est,	Approximate
filled i		ahock, pr heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final  disease or condition														
uiri 24 ely fille nation, t, the		disease or condition resulting in death)	<b>→</b>	Cor	iges	tiv	е Не	eart	Fa	ailuı	ce					24 hours
completely ial, cremati					(OR AS A											24 HOULD
executed within 24 than and completely fille oburial, cremation, matic event, the	Z	Consensatelles that are dist		Isc	hem	ic	Hear	ct D	ise	ease						3 years
8 0 6	CERTIFICATION	Sequantially list condition if any, leading to immediate	liata	DUE TO	(OR AS A	CONSEC	UENCE OF	<b>ጉ</b> :								Jear
he death certificate be the attending physician Mental Hygiene prior to njury, or other traur	2	cause. Enter UNDERLYII CAUSE (Disease or injur														
ing p		that initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEO	UENCE OF	ን:								
death certificate attending physiental Hygiene print, or other t	띩	in a duting at the		1												
s that the death ned by the atter ith and Mental any injury, o		PART II. Other significan	nt condition	s contributing to	death bu	it not re	sulting i	n the un	dariyin	ng cause g	Iven in	Part i. 24a.	WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
signed by the Health and Inws any In	MEDICAL												PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
usigned in signed Health ows an	8											-   10	YES 2	NO NO	1	OF DEATH?
been sign to of Healt		DID TOBACCO US	SE CONTE	DIBLITE TO CA	LISE OF	DEAT	L VI	s 🗆 :	JO F		EDTAIN					1 NES 2 NO
law lept 23	SICIAN:	25. WAS CASE REFERRED TO		ADDIL TO CA			-	H (Check			EKIAIP	4 III				
PHYSICIAN: The this certificate h with the State I writed, or item	Sic	EXAMINER?  1 YES 2 TO NO		HOSPITAL:				OTHER	₹:							
SICIA certif	РНҮ	27. MANNER OF DEATH		28a. DATE OF		HABINE 3	28b, TIM	- V		JURY AT	sidence	8 Other (Spe 28d. DESCRIB		ILIBY OCC	HOED	
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his hours after death with the State Ditem 28 is marked, or Item			Pending	(Month, D	ay, Year)			URY	W	ORK?	I NO	200. DESCRIB	E NOW IN	SUNT OCC	UNED	
After death	B	2 Culette	nvestigation	28a. PLACE O	F INJURY	- At hon	na, farm, s	treet, fact			, 100	28f. LOCATION	W /Street n	nd Number	or Rumi D	outs Alumbas
TTEN TOR: after	윤		Could not be letarmined	building,	atc. (Specif	(y)						City or Tox	vn, State)	no moniber	OF FIGURES 23	odie Namber,
DIRECTOR: After hours after death item 28 is male	LET	29a. CERTIFIER								-						
로 기가 되	M P			CIAN: To the beat of												
HOSPITAL FUNERAL WITHIN 72 F	COMPL		-	T: On the beats of a	camination	and/or in	rveatigatio	n, In my o	pinion, o	death occur	ed at the	lime, data and	place, and	d dua to the	s cause(s)	and manner as stated.
HH H B B B B B B B B B B B B B B B B B	BE	296. SIGNATURE AND TITLE	OF CERTIFIER	11to	11	00/	7			29c. LICE			T	29d. DATE	SIGNED	(Month, Day, Year)
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: I	10	(	DIM	1/1/Ou	101	111	, ,			D27	7544			J	lune	3, 1995
	- 1	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEA	TN (ITEM	27) (Туре,	Print)								
			rello,	M.D. 3	10 W	est	Nint	h St	ree	t, Fr	eder	cick, M	id. 2	21701		
		31. DATE FILED (Month, Day, )		32. REGISTRA	PUE SIGNA	TURE	1 .0	4								
		JUN 0	0 1330	0	- word	- N	andre	13.								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

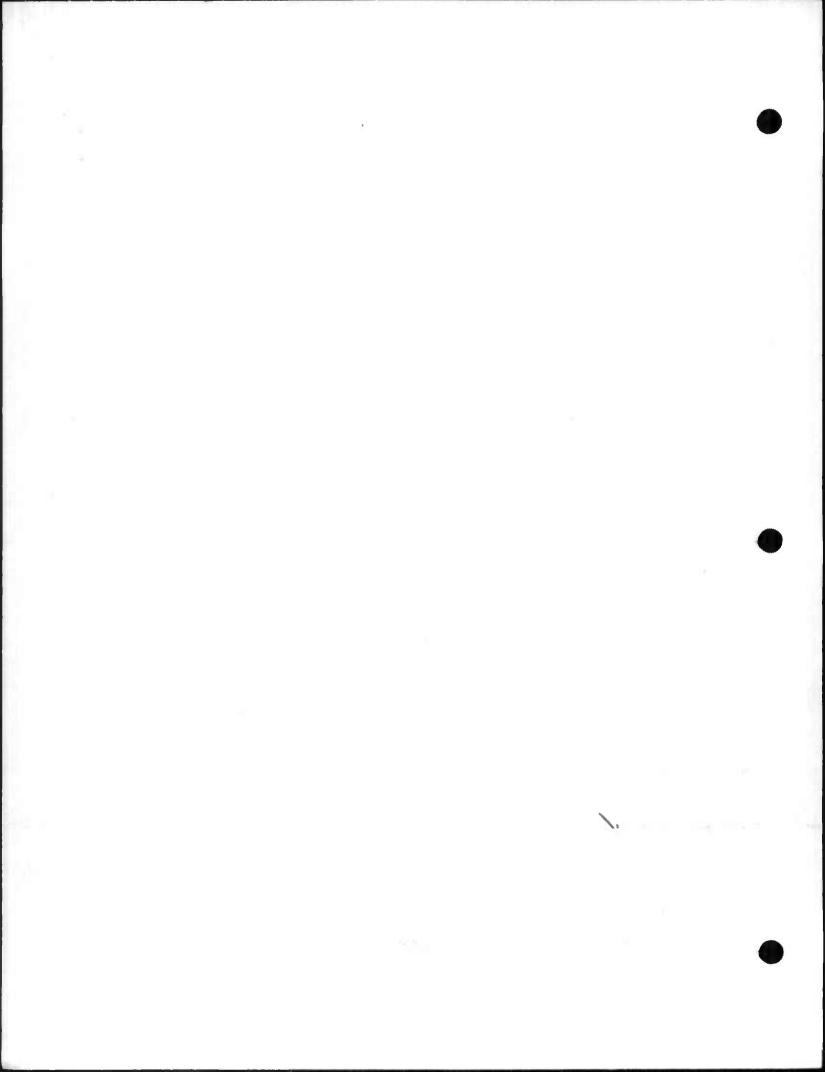
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HI		NENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, La					2. DATE OF OEATH		3. TIME OF DEATH			
	CHARLES		HANCOCK			-	1995	8:00 am			
	4. SOCIAL SECURITY NUMBER 220-16-9876	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTHPLACE (State or Foreign untry)			
	88. FACILITY NAME (If not institution, gr	O		OL CITY TOWN O	R LOCATION OF DEA	January 1,1	927	Maryland			
E E	936 James Ct.			Salis	F DEATH						
2	RESIDENCE OF DECEDENT										
DIRECTOR	10e. STATE 10b. CO. Maryland W	icomico		TOWN OR LOCATE			10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER				ZIP CODE	_	10a CITIZEN C	1X YES 2 NO			
FUNERAL	936 James Ct.				21801		USA				
5	11. MARITAL STATUS					C ORIGIN? (Specify Ya	8 or No- 14. R	ACE — American Indian,			
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	DATES		city Cuben, Mexican, 2 X NO Specity:	, Puerto Ricen, etc.)	S	lack, White, atc.				
	15. DECEDENT'S I	EDUCATION	16a. DECEDENT'S U	SUAL OCCUPATION	N .	18h KIND OF BU	SINESS/INDUSTR	ite			
E	(Specify only highest gi	rade completed)  College (1-4 or 5+)	(Give kind of wo	irk done during most	t of working	loc. Killo of Bo	5111E33/111D03/11				
COMPLETED	12	2	Masonry	Instruc	tor	Educa	ation				
	17. FATHER'S NAME (First, Middle, Last)  Jessie	Hancock			18. MOTHER'S NAM Bessie	E (First, Middle, Maiden	_				
BE	19s. INFORMANT'S NAME (Type/Print)	naticock	10h MAILING	DDBERR (Charles		oute Number, City or Tow	Jones				
5	Lavina M. Hanc	ock				bury, MD					
	20a. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 F		b.PLACE AND DATE OF	DISPOSITION (Nam	ne of		CATION — City or	Town, State			
	4 Donetion 5 Other (Specify)		metery, crematory or oth VICOMICO I				alisbury	,MD			
	21. SIGNATURE OF FUNERAL SERVINGE	LICENSEY	1	Holl	oway Fun	eral Home					
_	· WIC	Valloun	h	501	Snow Hil	1 Rd., Sa	lisbury,	MD 21801			
	23. PART i. Enter the diseeses, shock, or heart failu	or complications that cause ire. List only one cause on a	d Me death. Do no each line.	t enter the mod	le of dyling, such	as cerdlec or resp	iratory arrest,	Approximate interval Batween			
	iMMEDIATE CAUSE (Finei disease or condition	Marie a	N- 1					Onset and Death			
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	100				Syrs			
Ž	Companielly list and did as	Б									
ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF)								
E C	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF)								
CERTIFICATION	resulting in death) LAST	d									
	PART II. Other significant condit	tions contributing to death it	but not resulting in	the underlying	cause given in P	art I. 24s. WAS AN	AUTOPEY	24b. WERE AUTOPSY FINDINGS			
CAL				and anaditying	g.vo, .	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
밀						_ 1 TYES 2	NO	OF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CON	NTRIBUTE TO CAUSE C	OF DEATH YES	ON D	UNCERTAIN						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER2	HOSPITAL:	26. PLACE OF DEATH	(Check only one)	5/						
ΙΥS	1 TYES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	I ☐ Nursing Home	/						
	Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	RY WOR	HY AT IK? ES 2 NO	28d. OESCRIBE HOW I	NJURY OCCURED				
ЭВУ	2 Accident Investigation 3 Suicide 8 Could not	28s. PLACE OF INJURY	Y — At home, farm, str			281. LOCATION (Street )	and Number or Rur	al Route Number,			
IEI	4 Homicide detarmined		icny)			City or Town, State)					
COMPLETED		IYSICIAN: To the best of my know									
S	one) 2 MEDICAL EXAM	MNER: On the basis of examination	on and/or investigation	In my opinion, dea	ath occured at the ti	me, data and place, an	d due to the caus	e(a) and manner as stated.			
BE	296. SIGNATURE AND TITLE OF CERT	Fier //	) inas		29c. LICENSE NUMB	BER	29d. DATE SIGN	ED (Month, Day, Year)			
10	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF OR	EATH (ITEM 27) (Tono 1	(Print)	DOG.	418	16-	5-15			
	David Cours	11 mm 14		0/159	5.1	(L .)	un z	167			
								A V /			
	JUN 0 5 19	32 REGISTRAR'S SIGN		3/1 3/ 3	- [/	1	00	80/			

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the find mithing of the state	De mon whim it, hours are used with the Sale copt, or regula and menta righer, provide who will be medical examiner must be notified at once,	
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9	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first within 27 hours after death with the Strat Days of Bookh and Mandal Banking order to buried committee of the commit	= =	
PITA	ERAI	T	
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							20	18530
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	EALTH AND I	MENTAL HYG REG.		
	1. DECEDENT'S HAME (First, Middle, Last)			. /		2. DATE OF DEAT	DAW	3. TIME OF DEATH
		OLD MITCHI	CLL (In yrs, lest birthdev)	HOWAI	2)	MAY o	28,199	
	220-32-9778	∰ M 2 □ F	83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)  MD •
000	9a. FACILITY HAME (If not institution, give street				R LOCATION OF DE	ATH		TY OF DEATH
유	PENINSULA REGIONA	L MEDICAL (	ENTER	SAL	ISBURY		MI	COMICO
DIRECTOR	10e. STATE 10b. COUNTY			Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	MD . SOMI	ERSET	CR	ISFIELI				1 TES 2 NO
FUNERAL					ZIP CODE			EN OF WHAT COUNTRY?
NE NE	3207 CALVARY RO	JAD 2. WAS DECEDENT EVER II	HIIS ADMED		21817 EHDENT OF HISPAN	IIC OBIONIS (BII		S.A.
	1 Never Merried 2 Married	FORCES? 1 YES	2 V HO	If yes, spi	city Cuban, Mexica 2 NO Specify	n, Puerto Rican, etc	y 168 or No.—	14. RACE — American Indian, Black, White, atc.
BY	3 Widowed 4 X Divorced				AT NO specify	·-		WHITE
TED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TIOH mpleted)	(Give kind of	Work done during mo	H st of working	16b. KIND O	BUSINESS/IHOU	JSTRY
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 8+)	RIISTN	ESSMAN		SET	F-EMPI	OVED
NO	17. FATHER'S HAME (First, Middle, Last)		DODIN	IJODI IIII	18. MOTHER'S HA	ME (First, Middle, Mi		301110
BE C	ERTON HOWA	ARD				TYLER	100 000000	
TO B	19a. INFORMANT'S NAME (Type/Print)	II D D	19b. MAILING	AODRESS (Street a	nd Number or Rural I	Poute Number, City o	Town, State, Zip	Code)
	CHARLES M. HOV							BURY, MD. 21801
	1 KBurlet 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	of from State 20b	PLACE AND OATE	of disposition (No. other place)	me of	1		Hty or Town, State
	21. SIGNATURE OF FUNERAL SERVICE CICEN		IIISIIE		O ADDRESS OF FA		KISFII	ELD, MD.
	1.444	V.	41	POLINE	C TRITATE	DAT HON	D CAT	COUDY VD
	23, PARTI. Enter the dispuses, or con	polications that caused	ths death. Do					ISBURY, MD.
	shock, or heart failure. Lis	only one cause on a	ach line.		, , ,		oopmutoty zitt	Interval Between Onset and Death
	disesse or condition resulting in death)	Rubture	- Aosta	a Anei	irism			30 min
		DUE TO (OR AS A	CONSEQUENCE O	f):	1			-
NO	Sequentially list conditions, b.	DUE TO COR AS A	COHSEQUENCE O	D.				8 YVS
RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	(00L 10 (0H N3 N	CONSEQUENCE O	().				
Ē	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				
CERI	resulting in death) LAST	marked 1	my ho thy	modesur				unham
	PART II. Other significant conditions of	contributing to death b	ut not resulting	in the underlying	csuse given in	Part I. 24e. WA	S AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
	Chyonic Yenol	contributing to death b	ut not resulting	in the underlying	- A .	PE	FORMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE
	//	contributing to death b	C )	in AoA	- A	PE		AMAILABLE PRIOR TO
MEDICAL	Chronic renal  Coronom alim  DID TOBACCO USE CONTRIE	Joilure; discase BUTE TO CAUSE O	Clots; Ember	in AoA h to lee	na Aveyr	1 PE	FORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Chyonic yend  Coronem arland  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?	disease BUTE TO CAUSE O	Clots; Embé F DEATH YE 26. PLACE OF DEA	in AoA h to leg ES   NO   TH (Check only one)	nc Areyr	1 PE	FORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: MEDICAL	Chyonic yend Coronem alima DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	discase BUTE TO CAUSE O	F DEATH YE 26. PLACE OF DEA	M AOA  L to Leg  ES NO TH (Check only one)  OTHER:  4 Hursing Home	Shikaey UNCERTAIN	PEI 1 VE	REPORMED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN: MEDICAL	Chyonic Yend  Coronem alim  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH  1   Natural 5   Pending	disease BUTE TO CAUSE O	F DEATH YE 28. PLACE OF DEA etient 3 DOA	TH (Check only one)  OTHER: 4   Hursing Home HE OF   28c. INJURY WO	UNCERTAIN  5   Residence  BRY AT	1 - YE	REPORMED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	Chyonic yeard  Coronic yeard  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   760  27. MANNER OF DEATH  1   Natural 5   Pending Investigation	BUTE TO CAUSE O  SPITAL: Inpatient 2 = ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)	F DEATH YE 26. PLACE OF DEA attent 3 DOA 28b. TIM IN.	TH (Check only one)  OTHER: 4   Hursing Home HURY M   1   Y	UNCERTAIN  5   Reeldence  DRY AT  HC?  ES 2   HO	8 Other (Specify, 28d, DESCRIBE H	OW INJURY OCC	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Chyonic yeard  Coronic yeard  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   Yes 2   No  27. MANNER OF DEATH 1   Natural 5   Pending Investigation	BUTE TO CAUSE O  OSPITAL: Inpetient 2 = ER/Outp  28e. DATE OF IHJURY (Month, Day, Year)	F DEATH YE 26. PLACE OF DEA attent 3 DOA 28b. TIM IN.	TH (Check only one)  OTHER: 4   Hursing Home HURY M   1   Y	UNCERTAIN  5   Reeldence  DRY AT  HC?  ES 2   HO	8 Other (Specify, 28d, DESCRIBE H	OW INJURY OCC	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	Chychic Yellol  Coronan allow  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Nstural 5 Pending Investigation  2 Accident Investigation  3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only)  1 CERTIFYING PHYSICIA	BUTE TO CAUSE O  SPITAL: Inpatient 2 = ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)	F DEATH YE 28. PLACE OF DEA entient 3 DOA 28b. TIM IN.  At home, farm, 1	TH (Check only one)  OTHER: 4   Hursing Home IE OF IUNY M   28c. INJ! WOI 1   Y streat, factory, office	UNCERTAIN  5   Reeldence  JIRY AT  AR7  ES 2   HO	6 Other (Specify, 28d, DESCRIBE H	OW INJURY Occi	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,
ED BY PHYSICIAN: MEDICAL	Chychic Yellol  Coronan allow  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	BUTE TO CAUSE O  IOSPITAL: Inpatient 2 = ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)  28a. PLACE OF IHJURY building, atc. (Spec	F DEATH YE 28. PLACE OF DEA  28b. TIM  N.  At home, farm, sidy)	TH (Check only one)  OTHER: 4   Hursing Home IE OF 28c. INJURY WO 1   Y streat, factory, office	UNCERTAIN  5   Residence  JRY AT  18C?  ES 2   HO	8 Other (Specify, 28d, DESCRIBE H 281. LOCATION (Sichly or Town, 3)	OW INJURY Occi	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,
E COMPLETED BY PHYSICIAN: MEDICAL	Chychic Yellol  Coronan allow  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DOSPITAL: Inpetient 2 ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)  28a. PLACE OF IHJURY building, atc. (Spec	F DEATH YE 28. PLACE OF DEA  28b. TIM  N.  At home, farm, sidy)	TH (Check only one)  OTHER: 4   Hursing Home IE OF 28c. INJURY WO 1   Y streat, factory, office	UNCERTAIN  5   Residence  JRY AT  18C?  ES 2   HO	8 Other (Specify 28d, DESCRIBE H  281. LOCATION (St. City or Town, St. City or Town,	OW INJURY OCCI reet and Number of late)  manner as state s, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   MO  27. MANNER OF DEATH  1   Natural 5   Pending Investigation  3   Suicide 8   Could not be detarmined  29e. CERTIFIER (Check only One) 2   MEDICAL EXAMINER:  29b. SKE-ATURE AND TITLE OF CERTIFIER	DOSPITAL: Inpetient 2 ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)  28a. PLACE OF IHJURY building, atc. (Spec	F DEATH YE 26. PLACE OF DEA  atlent 3 DOA  28b. TIM INJ  — At home, farm, sidedge, death occurring and/or investigation	TH (Check only one)  OTHER: 4   Hursing Home BE OF JURY M   28c. INJ WOI 1   Y  streat, factory, offica	UNCERTAIN  5   Residence  PRY AT  AR?  ES 2   HO  and place, and dua  ath occured at the	8 Other (Specify 28d, DESCRIBE H  281. LOCATION (St. City or Town, St. City or Town,	OW INJURY OCCI reet and Number of late)  manner as state s, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH O
E COMPLETED BY PHYSICIAN: MEDICAL	COYONGY CHOOL  COYONGY CHOOL  COYONGY CHOOL  DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DOSPITAL: Inpetient 2 ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)  28a. PLACE OF IHJURY building, atc. (Spec	F DEATH YE 26. PLACE OF DEA  atlent 3 DOA  28b. TIM (N)  At home, farm, 1  ledge, death occurr n and/or investigation  ATH (ITEM 27) (Type)	TH (Check only one)  OTHER: 4   Hursing Home BE OF JURY M   28c. INJ WOI 1   Y  streat, factory, offica	UNCERTAIN  5   Residence  PRY AT  AR?  ES 2   HO  and place, and dua  ath occured at the	8 Other (Specify 28d, DESCRIBE H  281. LOCATION (St. City or Town, St. City or Town,	OW INJURY OCCI reet and Number of late)  manner as state s, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH O
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	BUTE TO CAUSE O  OSPITAL: Inpatient 2 = ER/Outp  28a. DATE OF IHJURY (Month, Day, Year)  28a. PLACE OF IHJURY building, atc. (Spec	F DEATH YE 28. PLACE OF DEA setient 3 DOA 28b. TIM HALL HALL HALL HALL HALL HALL HALL HAL	TH (Check only one)  OTHER: 4   Hursing Horm INDITY M   1   Y  streat, factory, offica  ed at the time, data on, in my opinion, de	UNCERTAIN  5   Residence  PRY AT  AR?  ES 2   HO  and place, and dua  ath occured at the	8 Other (Specify 28d, DESCRIBE H  281. LOCATION (St. City or Town, St. City or Town,	OW INJURY OCCI reet and Number of late)  manner as state s, and due to the	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  URED  A Rural Route Number,  d.  csuse(a) and manner as stated.  SIGNED (Month, Day, Year)



TO BE COMPLETED BY FUNERAL DIRECTOR

NAME Hubbert

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR		STATE OF N		DEPART					MENTA	L HYGIEN	E		
1. DECEDENT'S NAME (First	Middle, Last)				OAT L	- 01	DEA		2. DATI	E OF DEATH		1	. TIME OF DEATH
Theresa	L.	Hubbert							MONT	TH DA	<b>Y</b>	95	2250
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. Ia	st birthday)	JF UNDER	1 YEAR	IF UNDER	1 24 HRS.	7. DATE	OF BIRTH		0.000000	ACE (State or Foreign
006-07-57	748	1 🗌 M 2 💢 F	77	YRS.	HONTHS	DAYS	HOURS	MIN.	5 <sup>Mon</sup>	28-18		Country	aine
Sa. FACILITY NAME (If not in					9b. CITY	TOWN O	R LOCATI	ON OF D	EATH		9c. COU	NTY OF DEA	
Union Hos	pita	1				E1k	ton	ļ				Ceci:	1
RESIDENCE OF DEC				-									
Md •	10b. COUNT	Cecil		10c. CITY,		ctor						10	Dd. INSIDE CITY LIMITS?  YES 2 NO
10e. STREET AND NUMBER						101	ZIP COD	E			40- 0/7		
150 E. M	fain :	Street				101	219	_			10g. CI	U.S	AT COUNTRY?
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	PMED						N? (Specify Yes	or No	14. RACE -	- American Indian.
1 Never Married 2 1 3 Wildowed 4 Divo		IF YES, GIVE W	AR OR DATES	NO	1	if yes, spe	elfy Cuba 2 XNO	Specif	n, Puerto y:	Rican, etc.)			White
15. DEC	EDENT'S EDU highest grade	CATION	16e. D	ECEDENT'S U	SUAL O	CCUPATIO	N		16	b. KIND OF BUS	INESS/INC	DUSTRY	
Elementary/Secondary (0		College (1-4 or 5 +	)	omema	retired.)		st of Workii	ng		At	ho	me	
17. FATHER'S NAME (First, M	iririla ( aet)												
Albert		11								Middle, Meiden rsenau			
190. INFORMANT'S NAME (7) Denise S.		010	19	b. MAILING A	DORESS	(Street ar	nd Number	or Rural	Route Nun	nber, City or Town	n, State, Zip	Code)	01001
				205	Mea	adow	Cr	еек	Lai	ne Elk	cton	, Ma	. 21921
20e. METHOD OF DISPOSITI	in 3 □ Rem	loval from State		AND DATE OF			ne of		DAT	7E 20c. LO	CATION -	City or Town	, State
4 Donation 5 Other			R.	A. Fe					pany	y Wes	st C	hest	er, Pa.
21. SIGNATURE OF FUNERAL	L SERVICE LI	CENSEE					D ADDRE		HOI	259	E.	Main	n St.,
Eslur	el"	Clow,	n							Elk			. 21921
23. PART I. Enter the di shock, or he	sesses, or	complications that List only one cau	ceused the de	esth. Do no	t enter	the mod	de of dy	ing, suc	h as car	diac or respi	ratory sn	reat,	Approximate Interval Between
IMMEDIATE CAUSE (Fin		Res		eilu	no	1/	Are	on n	101				Onset and Death
resulting in death)	7	a. DUE TO	OR AS A CONSE	OUENCE OF		10	7 7 6	701					-
	_	Rem	21/0/5	cinh	12	d	13	921	20				
Sequentielly list conditi		QUE TO	OR AS A CONSE	OUENCE OF):		0	, ,		, –	hisa			
cause. Enter UNDERLYI	NG	pen	Ohon	2/	11	25	CM	Bu	- (	Y Sec	VSC.		İ
CAUSE (Disease or inju that initiated events	η )	DUE TO	OR AS A CONSE	OUENCE OF):			0-7						†
resulting in death) LAS	r 📳	d.											
DADT II. Other clearline	-0 dial											100	1
PART II. Other significe	nt condition	ontributing to	deeth but not i	resulting in	the un	deriying	ceuse g	lven in	Part I.	24a, WAS AN PERFOR		24b, Wi	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
- EMININGS	ena,	ASC	70,17	ype	18	CM?	SICL	2	_	1   YES 2	NO		OMPLETION OF CAUSE F DEATH?
	-			J					'				YES 2 NO
DID TOBACCO U		RIBUTE TO CA	USE OF DEA	TH YES	1 🗵	40 🗆	UNC	ERTAII	V 🗆				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLA	E OF DEATH									
1 TES 2 MLNO		1 Delinpatient 2	ER/Outpatient 3		OTHER Nurs		5 🗆 Re	sidence	6 🗆 Othe	er (Specify)			
27. MANNER OF DEATH	1500	28a. DATE OF (Month, De	INJURY y, Year)	28b. TIME		28c. INJU			28d. DE:	SCRIBE HOW IN	LJURY OC	CURED	
	Pending nvestigation				М	1 🗌 Y	ES 2	NO					
	Could not be letermined	28e. PLACE Of building,	INJURY — At he rtc. (Specify)	me, ferm, str	eet, facto	ory, office			28f. LOC City	ATION (Street as or Town, State)	nd Number	or Rural Rout	e Number,

29e. CERTIFIER (Check only one)

In my opinion, death occured at the time, data and place, end due to the cause(e) and manner ee stated. 29c. LICENSE NUMBER

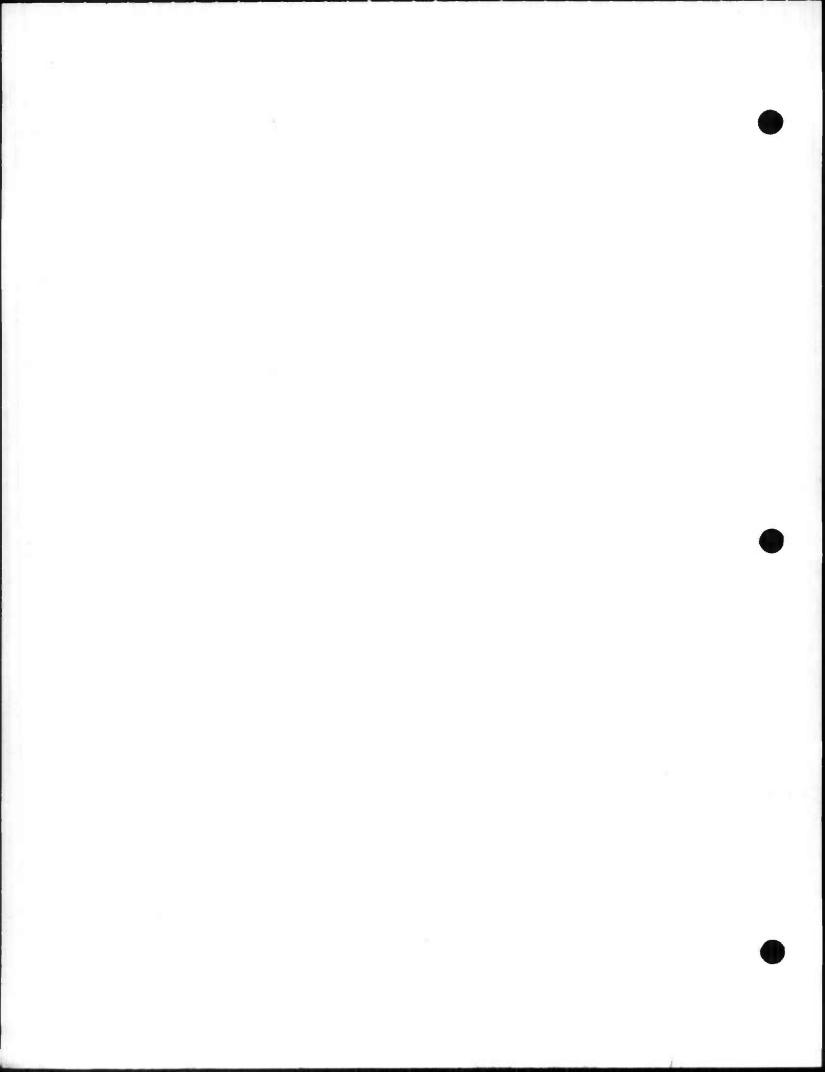
COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND

5 5 4ite

29d. DATE SIGNED (Month, Day, Year)

5 1995 32. DEGISTRAR'S SIGNATURE

		1. DECEDENT'S NAME (First, Middle, Lost)	PH		Ho	LT, SR.	2. DATE OF DEATH MONTH D	16 1991	3. TIME OF DEATH
2/8			. SEX 6. AGE (	In yrs. last birthday)  YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov 27,	Co	ATHPLACE (State or Foreign untry)
2, 3 should	стоя	99. FACILITY NAME (If not institution, give street  3422 NAVY DAY DRI RESIDENCE OF DECEMENT				LAND		9c. COUNTY O	
f. Pages 1,	DIREC	10a. STATE 10b. COUNTY	E GEORGES		Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
sit permit.	ERAL	100. STREET AND NUMBER 3422 Navy Day Driv	70			1. ZIP CODE 20746			F WHAT COUNTRY?
020 physician. burial-transit	FUNE		. WAS DECEDENT EVER IN FORCES? 1 2 YES	2 NO	13. WAS DEC	s or No- 14, R/	States ACE — American Indian, ack, White, etc.		
nding as the	ED BY	3 [V] Wildowed A   Disposed	953 191	55		2 NO Specify		В	LACK
	Ē	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	vork done during mo e retired.)			SINESS/INDUSTRY	
the hospital the hospital detached to	COMP	12. 17. FATHER'S NAME (First, Middle, Last)		Carpent	ter	16. MOTHER'S NA	D.C. G	Sovernme Surname)	nt
MARYL retained by 5 should be notified at	BE	John Holt  19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		M. Hinesl		
E, No be re sage 5 be no	5	Keith W. Holt		3422 M	Navy Day	Drive,	Suitland,	Marylan	
MOR le 6 mi rector,		1 Burlel 2 Cremetion 3 N Removel 4 Donation 5 Other (Specify)	from Stata Com AI	PLACE AND DATE OF THE COLOR OF	per disposition (No her disce) NERAL H	OME		DDOCK,	
BALTIN  Ber death. Pag  the funeral di  wal.  st examiner		21. SIGNATURE OF FUNERAL SERVICE LIDENS	u d	M859	ALEX	ANDER S. MARLBOR	POPE FUNE	RAL HOM	ES LE,MD 20747
urs af In by r remo		23. PART I. Enter the diseases, or com shock, or heart fellure. List	plications that ceused t only one ceuse on ea	I the death. Do n	ot enter the mo	de of dylng, such	as cardiac or reapi	iratory arrest,	Approximata Interval Between
the the		IMMEDIATE CAUSE (Final disease or condition resulting in death)	V.ENTA	ZICUL	AR	FIBRI	LLATIO	N	Onset and Death
be executed within sian and completely or to burial, crema aumatic event,	TION	Sequentially list conditions, If any, leading to immediate	DOE TO (ON AS A	CONSEQUENCE OF					
h certificate by anding physicial Hygiene prior or other tra-	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	):				
KDS, at the deat by the atternal Mental y injury.		PART II. Other significent conditions co	ontributing to death be	ut not reaulting in	n the underlying	g ceuse given in	Part I, 24s. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
requires that the signed by of Health any thows any	MEDICAL	CHRONIC IS	CHEMIC F	TEART	DISE	SE	1 YES 2		COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
- A 0 - W		DID TOBACCO USE CONTRIB		F DEATH YE		UNCERTAIN	10		1 1 1 2 2 1 10
F VIIAL SICIAN: The lav certificate has the State Dep	PHYSICIAN:	1 YES 2 NO 1	OSPITAL: Inpetlent 2 ER/Outpe		OTHER: 4   Nursing Hom	e 5 KRaaldenca	5 Other (Specify)		
DING PHYSIC After this ce death with t	ву Рн	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	JRY WO	URY AT RK? YES 2 NO	28d. DESCRIBE HOW to	NJURY OCCURED	
TTENDI TTENDI CTOR: A affer da	TED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, s	treat, factory, offic		261, LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,
東京日	COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE) 2 MEDICAL EXAMINER: 0	To the best of my knowled the basis of examination	edge, death occurre and/or investigation	d at the time, data n, in my opinion, d	and place, and due	to the cause(a) and men	oner as stated.	e(s) and menner as stated,
THE HOSP THE FUNE fled within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30, NAME AND ADDITION OF TEMPOR WHO CO	MD (ME	5)		29c. LICENSE NUM D 259	BER 25	29d, DATE SIGN	26, 1995
10	)	J. BENGER MD  31. DATE FILED (MORIT), Day, Year)		7720		NSIN A	ve, Be	thesda	Md 20814
		JUN 01 1995	32. REGISTRAR'S SIGN	artall					
									DHMH-16 Rev 1/89



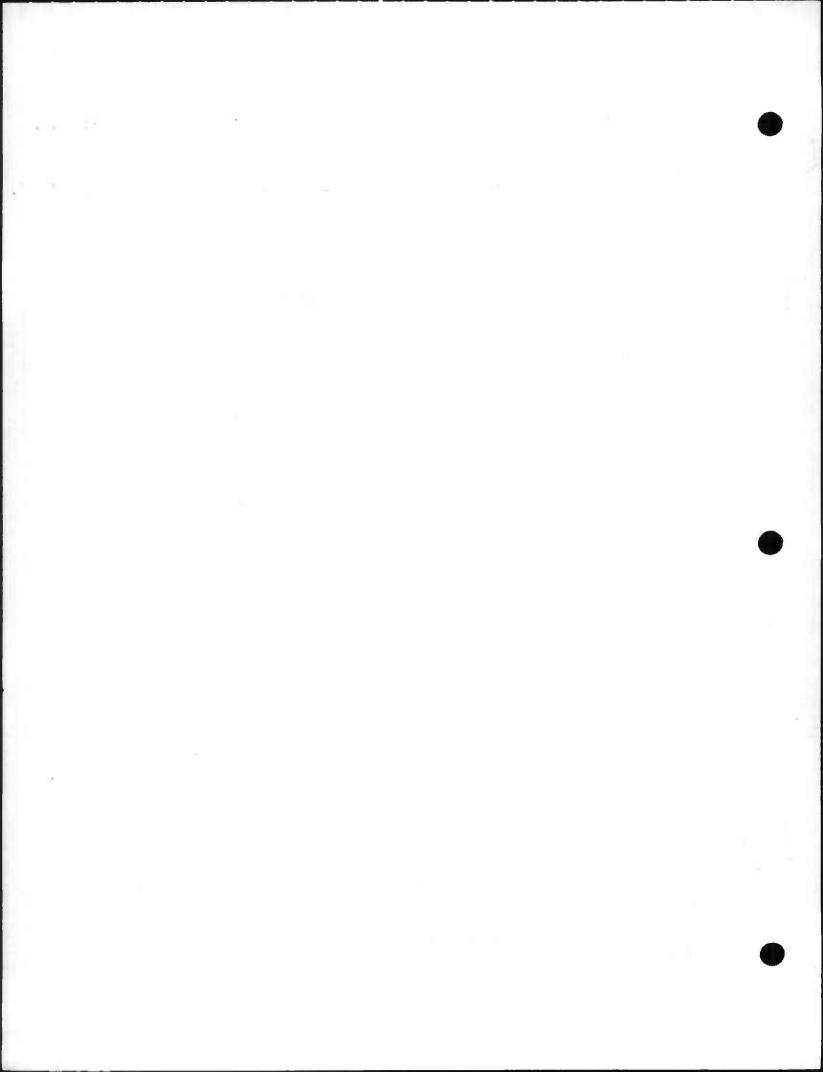
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The second of th
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STATE REGISTRAR CERTIFICATE OF DEATH REG. NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF OEATH MARY E. HOLOHAN May 26, 9:00 1995 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 K F YRS 577-46-8509 May 9,1904 91 Ireland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR #203 Prince Georges 2728 Loring Drive Forestville RESIDENCE OF DECEDENT 10a STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince Georges Forestville permit. 1X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 2728 Loring Drive USA #203 20747 retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ricas 1 ☐ YES 2 NO Specify: 1 Never Married 2 Married BY 3 🔀 Widowed 4 🗌 Divorced so White 15. DECEDENT'S EDUCATION (Specify only highest grade commit 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Marketing Representative Jelleff's Dept. Store 12th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 75 James Kenny Brigit Carmody BE notified 19e. INFORMANT'S NAME (Type/Print) 196\_MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)
9/15 Loudoun Avenue 2 John J. Holohan Manassas. Page 6 may be VA 22110 pe 20e. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Mt. Olivet Cemetery 5/31 4 Donation 5 Other (Specify) Washington, D.C. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marshall's Funeral Home, Inc. hours after death. P. mas 4308 Suitland Rd. Suitland, MD 20746 completely filled in by the medical 23. DEST 1. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximats shock, or heart failure. List only one cause on each line. Interval Betwe ŏ **IMMEDIATE CAUSE (Final** Onset and Death the disesse or condition Congestive Heart Failure resulting in death) 2 days traumatic event, crem DUE TO (OR AS A CONSEQUENCE OF) burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to other t CAUSE (Disesse or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 injury. PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t Health and any 1 TES 2 NO tt. of Heal OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗌 NO 🗵 UNCERTAIN 🗆 PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetlent 3 - DOA 4 Nursing Home 5 Residence 6 XOther (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, With this 1 Natural 5 Pending М 1 YES 2 NO After the ВУ 2 Accident 26e. PLACE OF INJURY — Al home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 90 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d COMPLETED 8 Could not be 4 Homicide 28 S 29e. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) end manner as stated. (Check only one) FUNERAL within 72 h = 2 MEDICAL EXAMINER: On the b nination and/or investigation, in my opinion, death occured at the time, date and place, and dua to the cause(e) and manner se stated. IMPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d, DATE SIGNEO (Month, Day, Year) BE 異性質 D15625 223 5-26-95 2 COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Daniel J. Boyle, M.D.-10313 Georgia Ave. #201 Silver Spring, MD 20902 31. DATE FILEO (Month, Day, Year) elia d'Euclear R

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8	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after or	The second secon
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	8	1
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		1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND I	MENTAL HYGIEN REG. NO						
		1. DECEDENT'S NAME (First, Middle, Last)  ELLEN L HOOK  2. DATE OF DEATH  3. TIME OF DEATH  3. 20 p. m.											
_AND_21215-0020 the hospital or attending physician. detached for use as the burlat-transit permit. Pages 1, 2, 3 should once.		4. SOCIAL SECURITY NUMBER  215-28-8529  5. SEX  1  M 2 X F 73			IF UNDER 1 YEAR	B HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug/20/19		BIRTHPLACE (Stote or Foreign Country) Maryland				
	СТОВ	9a. FACILITY NAME (If not institution, give stree  DOCTORS CO  RESIDENCE OF DECEDENT		OSPITAL		N OR LOCATION OF DE M-SEABROOK		PRIN	CE GEORGE'S CO				
	COMPLETED BY FUNERAL DIREC	10e. STATE 10b. COUNTY MD Anne A		ry, town on Lo vidson			10d. INSIDE CITY LIMITS? 1 YES 2 X NO						
		100. STREET AND NUMBER 3889 Greenmeadow L			N OF WHAT COUNTRY?								
		11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	IN U.S. ARMED 2 X NO DATES	13. WAS C	. RACE — American Indian, Black, White, etc. Specify: White								
		15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done during se retired.)	TRY								
2 8 E	BE CON	17. FATNER'S NAME (First, Middle, Last) Daniel R. Buck			18. MOTHER'S NAME (First, Middle, Meiden Surneme) Maude Wells								
ME, MARY may be retained by or, page 5 should b	10	Jackie Hickcox		3889	Greenme	eadow Lane	Poute Number, City or Tow 2/Davidsonv	/ille/N	/ID/21035				
EAL I IMOKE, er death. Page 6 may be the funeral director, page val.		20a METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	of from State cen	netery, cremetory or cremetory or cremetory	Nation	al	6/14 Arl	cation — city Lingtor	or Town, State				
BAL I IMOR after death. Page 6 m by the funeral director, moval.		Advent Memorial Services, Inc. Annapolis MD 21401											
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS IA CONSCOURNCE OF):											
ubs, P.O. BOA 66/10 the death certificate be executed the attending physician and com d Mental Hygiene prior to burial, of injury, or other traumatic ev	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. ASCATES  DUE TO (OR AS A CONSEQUENCE OF):  C. CHICAGO DISEASE OF THE CONSEQUENCE OF):  C. CHICAGO DISEASE OF THE CONSEQUENCE OF):  C. CHICAGO DISEASE OF THE CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
र इन्ते व	EDICAL C	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.  24a. WAS AN AUTOPSY PERFORMED?  1 □ YES 2X NO							24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
De fe	IAN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Chock only one)											
SICIAN: The certificate his the State D. or Item	IYSICI	EXAMINER?  1 YES 2 X NO  27. MANNER OF DEATH	IOSPITAL: Inpetient 2 - ER/Outp	patient 3 DOA	OTHER: 4   Nursing H	lome 5 - Realdence							
F E E	ву рну	1 X Netural 5 Pending 2 Accident Investigation	280. DATE OF INJURY (Month, Day, Year)		M 1	INJURY AT WORK?	28d. DESCRIBE HOW II						
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED.	3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify) 28. LOCATION (Street and Number or Rural Route No. City or Town, State)											
7 72 +	COMPL	29s. CERTIFIER  (Check only one)  2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.											
TO THE HOSPITO TO THE FUNERA De filed within 7 IMPORTANT: I	O BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Rachelle ale	ckin		29c. LICENSE NUN D44156	MBER 29d. DATE SIGNED (Month, Day, Year)  Ulolas						
		30. NAME AND ADDRESS OF PERSON WHO C	14300 Galler	nt Fox lo	Print)	Bowe,	MD 20715						
		31. DATE FILE (NOT 2 1995	P. REGISTRARIS SIGN	Kardall									



BALTIMORE, MARYLAND 21215-0020

under within 24 mours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours

31. DATE FILED (Morith, Day, Year)

JUN 08 1995

32. REGISTRAR'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Mours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /		TMENT ICATE					YGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DEATH		WE40	3. TIME OF DEATH
	<u>Catherine</u> F	Fran Hou	ick						June	1	199	95	2A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	st birthday)	IF UNDER 1	1 YEAR DAYS	IF UNDE		7. DATE OF (Month, De			6. BIRTH Country	PLACE (State or Foreign
	217-60-8555	1 - M 2 X	1 □ 1 2 1 2 1 4 3		ras. Months 6		HOURS MIN.		Jan :		252		shinaton. DC
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN O	R LOCATI	ON OF DE		71 1	9c. COUN		
CTOR	3419 Merrimac Road					Davidsonville					Arundel		
H	LIMI									10d. INSIDE CITY LIMITS?			
										1 - YES 2 XX40			
¥										HAT COUNTRY?			
E E	2960 November	Court				_	207	16			Unit	ed S	States
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. W	AS DECI	ENDENT (	OF HISPAN	NC ORIGIN? (S	pecify Yes		14. BACE	- American Indian
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE	XES 2 1	NO			2   Yelo	in, Maxicai Specify	n, Puerto Rica	n, etc.)		Specif	White, etc.
	15. OECEDENT'S EDI	I											' White
	(Specify only highest grad		(G	live kind of	USUAL OC	CUPATIO uring mos	N it of world	ng	16b, KII	ID OF BUS	INESS/IND	USTRY	
Ä	Elementary/Secondary (0-12)	College (1-4 or 5	+)	. Do NOT us									
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	4	P	<u>arale</u>	gal						ment	Offi	cer
									ME (First, Midd		Sumame)		
BE	Fletcher LeRcy H	ouck. Jr.							Simm				
ပြ	Inches to the same of		1						loute Number, (				
	Fletcher LeRoy H	ouck. Jr.						oad E	Bowie,				
	20a. METHOD OF DISPOSITION  1 Durial 2 Cremation 3 Ran	noval from State	20b. PLACE : cemetery, cre		thes alone t						CATION — C		
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE L		ker	mont	Mem	oria	I Ga	rden	s <sub>1</sub> 6/5/9	5 D	avidso	envil	le, Maryland
	Donald &	PENSEE	for		14	7 D	uke	of G	louces	n M. ter S	Tayl St. Ar	or F napo	uneral Home
	23. PART i. Enter the diseeses, or	compilections the	t caused the de	eth. Do r									Approximata
	shock, or heart fellure.  IMMEDIATE CAUSE (Finel	Liet Dniy ghe ceu	ise Dn each line	ð.	^			^				, ,	intervsi Between
	disease or condition				BV	eas	42	(H					Onset and Death
	resulting in death)	DUE TO	(OR AS A CONSE	OUENCE O	n:								(O YELLIN)
N N	Sequentially list conditions,	b											
CERTIFICATION	if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE O	ን:								
2	cause. Enter UNDERLYING CAUSE (Disease or injury	c											
	that initieted events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE O	F):								
1 1 1	roading in death) EAST	d											
	PART II. Other significant condition	ns contributing to	deeth but not r	recuiting	n the und	lerlying	Cause (	alven in I	Part i 24	MACAN	AUTOPSY	Last	WERE ALTROPON CHICAGO
MEDICA	Acute V	enal fe	21/12/10				11.54			PERFOR			WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
	ACUTE VENAL FAILURE  PERFORMED?  1 PES 2 NO COMPLETION OF CAUSE OF DEATH?												
≥									_		U		1 TES 2 NO
A N	OF WHA CLOS DESERVED TO MEDICAL												
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)  HOSPITAL: OTHER:												
×s	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)												
표	27. MANNER OF DEATH  1 Natural 5 Pending	26a. DATE OF (Month, D	INJURY ny, Year)	26b. TIM INJ	URY	28c. INJU WOR			28d. DESCRI	BE HOW II	JURY OCC	URED	
DO 2 Accident Investigation M 1 YES 2 NO													
<u>a</u>	3 Suicide 8 Could not be 28s. PLACE OF INJURY At home, farm, street, factory, office 28f. LOCATION (Street and Number or Pural Route Number,								oute Number,				
	4 Lectures certaining												
립	29a. CERTIFIER (Check only  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
COMPLET	one) 2 MEDICAL EXAMINI	ER: On the basis of a	camination and/or i	Investigatio	n, in my opi	Inlon, de	sth occur	ed at the t	lme, data and	place, and	due to the	cause(a)	and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	R/7					29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
0 8	7. Deloull	1,00					1	198	38				1, 1995
F	30. NAME AND ADDRESS OF PERSON WI				Print)		200	1 .0-	0	1 "			
		elouice			400	) E	5017	gat	P Kd	1	1616161	oolic	Med. 21401

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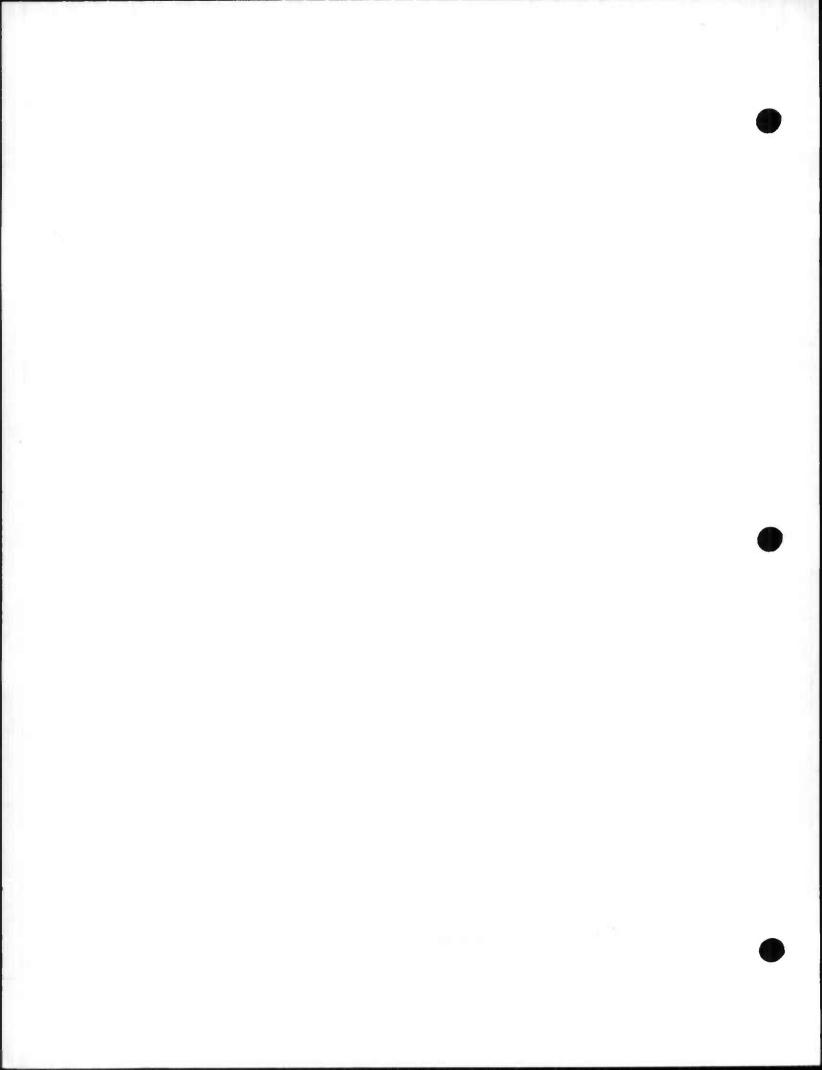
funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. Page 6 may be completely filled in by the rial, cremation, or removal. n and completely filled in to burial, cremation, or attending physician

BALTIMORE, MARYLAND 21215-0020 hours after death. executed with DIVISION OF VITAL RECORDS, P.O. BOX 68769 that the death certificate be requires HOSPITAL OR ATTENDING PHYSICIAN: The law

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Joffre Armand Heineck June 1995 11:35P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIFTTH (Month, Day, Year) Sept 20 1918 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN. 1 X M 2 - F YRS 318-18-3927 Illinois Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Anne Arundel Annapolis RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MID Anne Arundel Annapolis permit. 1 YES 2 NO FUNERAL 10s, STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 436 Ferry Point Road 21403 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.)
 T YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced White AAMII COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Naval Analyst United States Government once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Aime Paul Heineck BE Leonie Pallissard notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan K. Heineck 436 Ferry Point Road Annapolis, Maryland 21403 Pe 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 ◯ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Lincoln Crematory 4 Donation 5 Other (Specify) 6/6/95 Brentwood, Maryland 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 147 Duke of Gloucester St. Annapolis, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition the resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate prior cause, Enter UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 signed by the atte injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 YES 2 NO OF DEATH? 1 | YES 2 | NO t, of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: has be 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item EXAMINER? certificate to the State HOSPITAL: OTHER: 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 10 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1) Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation DIRECTOR: An hours after desirem 28 Is n 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide determined TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Itom 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 256 SIGNATURE AND THE OF CENTER 29c, LICENSE NUMBER 294. DATE SIGNED INTO MY, Day, Year) BE 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Stanley P. Watkins, M.D. 900 Bestgate Road Annapolis, MD 21401 (410-573-5300)

32. ABGISTRAB'S SIGNATURE Jaha d'Awaler Ranfell



DIVISION

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

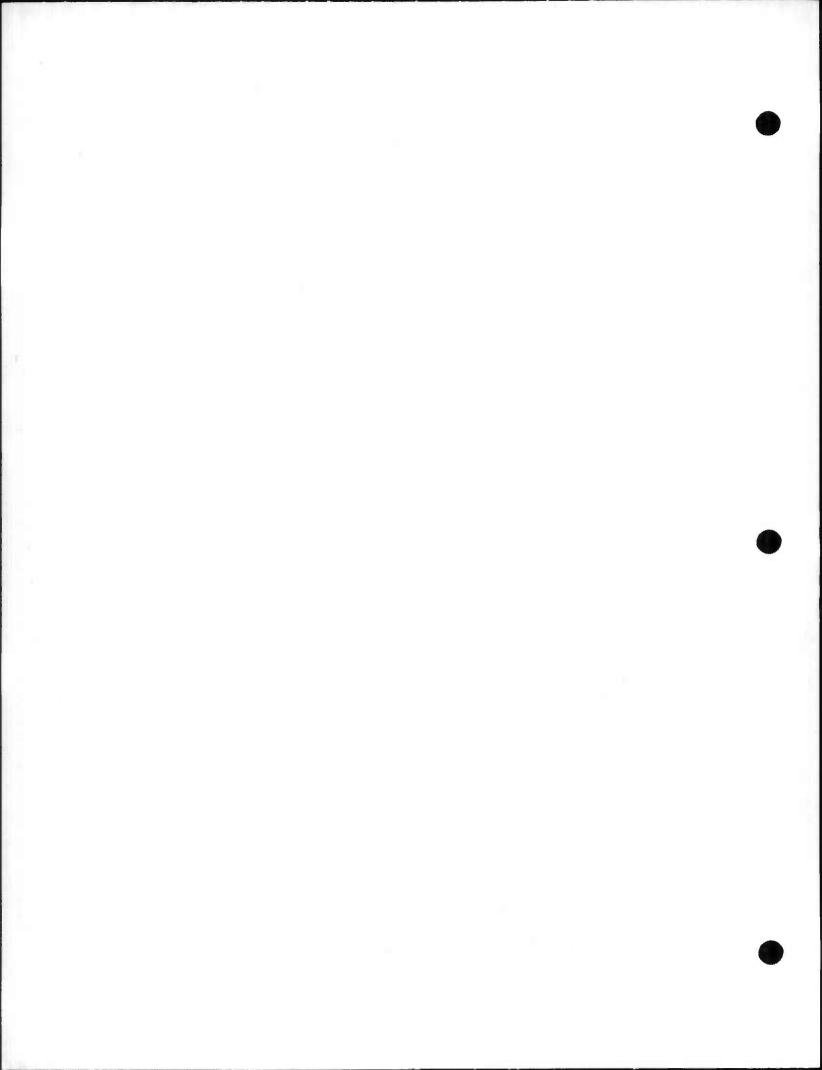
FOR STATE

		REGISTRAR				ICATE O		MENTAL HYGIEI REG. NO					
		1. DECEDENT'S NAME (First, Middle, LI DANIEL	FRENCH	ŀ	HOL	LIDAY	OKE	2. DATE OF DEATH MONTH	DAY - 9	3. TIME OF DEATH A			
pin		4. SOCIAL SECURITY NUMBER  213-22-1188  9a. FACILITY NAME (If not institution, g	1 M 2 □ F 83	(In yrs. las	YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) July 20	1911	BIRTHPLACE (State or Foreign Country) Maryland			
2, 3 should	ECTOR	Anne Arundel M	Medical Center				napolis	DEATH		e Arundel			
permit. Pages 1,	DIREC	10a. STATE 10b. COL	NTY		10c, CIT	Y, TOWN OR LOC	ATION			10d. INSIDE CITY			
ermit.	AL D	MD Ans	ne Arundel				apolis		T 40 - 017175	1 YES 2 NO			
nsit pa	ER/	303 State Stree	t					403		ted States			
15-0020 ending physician. as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYSE 2 NO IF YES, GIVE WAR OR DATES			ECENDENT OF HISP/ specify Cuben, Maxie ES 2 NO Speci		Black, White, etc.				
	E	15. DECEDENT'S (Specify only highest g		completed) (Give kind of work done during most of w				16b. KIND OF BU	JSINESS/INDUS				
AND 2121 the hospital or atti detached for use once.	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me.	Do NOT u	se retired.)		Dubi	lia Maa	les.			
The hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			000/	Craftsm		PUD!	ic Wor	KS			
# 8 4 X	BE C	William Hollid	ayoke					a Shipley					
MAR: retained 5 should notifiled	2	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or Tox					
2 8 9		Mary K. Hollie	20b BLACE AND DATE OF DISPOSITION (Along of										
F 6 ma ector, 1		1 K Burisi 2 Cremation 3 Removal from State   Competery, crematory or other State   Competery St. Anne's Cemetery June 9 1995 Annapolis, Mai											
BALTIMORE, after death. Page 6 may be by the funeral director, page noval. cal examiner must be		21. SIGNATURE OF FUNERAL SERVICE LICENSES  22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Hom  147 Duke of Gloucester St. Annapolis, MD											
in by reme		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause in each line.  Approxim											
tely fille mation, rt, the		immediate cause (Final disease or condition resulting in death)  a. Acute & Chronic Respiratory Failure											
68 wecute and c bunia	NO	Sequentially list conditions, If any leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):  LEADY SERVICE TO COR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury								Yeova			
P.O. Eath certifical trending physiene I, or other	CERTIF	that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  d. # Lung G								Pears			
RDS, at the dea by the atl and Menta y injury.	SAL	PART II. Other algolificent conditions	lone contributing to death b	ut not re		In the undariyi	ng ceuee given in			24b. WERE AUTOPSY FINDINGS			
	200	Acuta	Rowal Fo	عا	10			1 _ YES :	AMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
2 6 6 6	MEDI	DID TOPACCO HEE COL	oe dysil	ry !	u	uay .	7			1 TES 2 NO			
L Sept 23	PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL				S X NO [	UNCERTA	IN LI					
F VITAL SICIAN: The law certificate has the State Dep	Sic	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	etient 3	□ DOA	OTHER:	me 5 🗆 Residence	6 Other (Specify)					
~ ~ ~ ~ ~	BY PHY	27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigate	28a. DATE OF INJURY (Month, Day, Year)		28b. TIM	E OF 28c. IN	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUP	RED			
SIC TEND TEND OR: A fter d	<b>a</b>	3 Suicide 6 Could not determined	28a. PLACE OF INJURY building, etc. (Spec	- At hor	ne, ferm, i	streat, factory, offi	Ica	261. LOCATION (Street City or Town, State	and Number or	Rural Route Number,			
로 로 로 드	COMPLET		YSICIAN: To the best of my know INER: On the basis of examination							ause(s) and menner as stated.			
TO THE HOSPI TO THE FUNER be filed within	O BE C	201. SIGNAPORE AND TITLE OF CERTI	n (d)	~60				IMBER F2	29d. DATE S	TE SIGNED (Mgnth, Day, Year)			

Devoler Redall

ROW 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE AUTOPSY OF DEATH? 1 TES 2 NO JURY OCCURED 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (M nth, Day, Ybar)

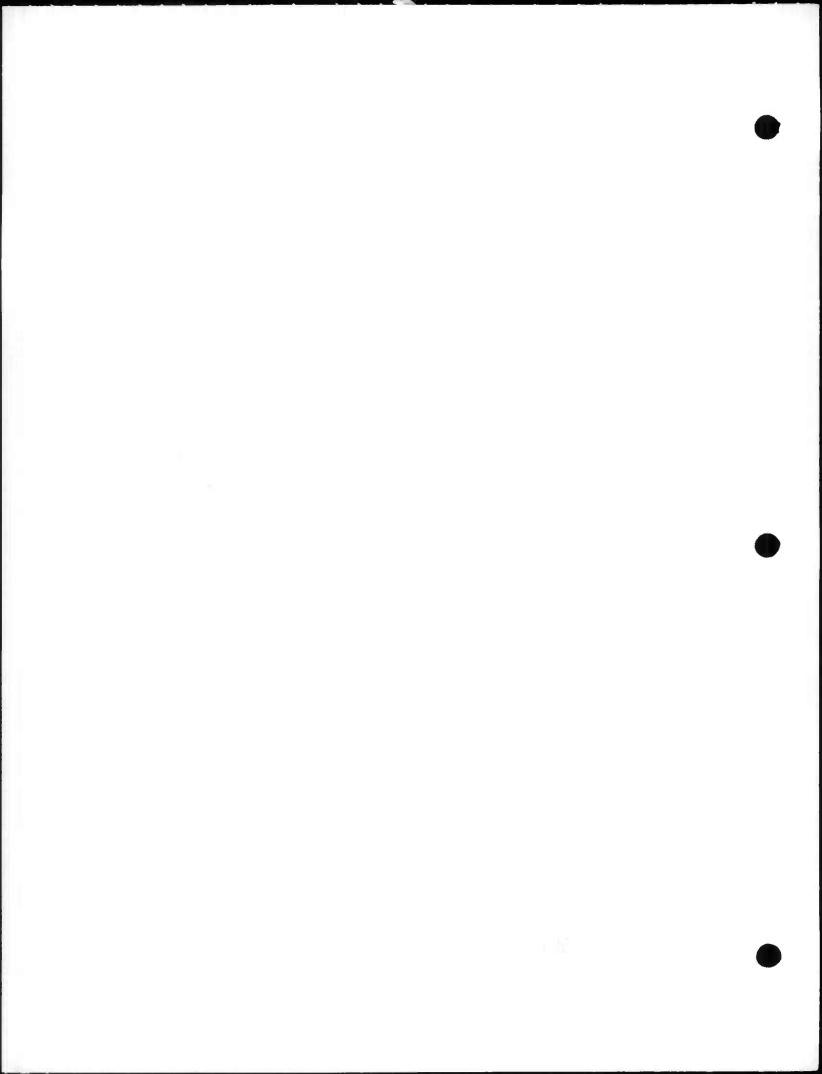
DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floor after death. Page 6 may be retained by the hospital or attending physician.	ils certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the five within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	MARTHA	Ε.		HORNIC	K	May 28, I	995 YE	9:15 p m			
	4. SOCIAL SECURITY NUMBER		'in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	0.1	BIRTHPLACE (State or Foreign Country)			
	212-24-2262	1 🗆 M 2 💢 F 8	YRS.	MONTHS DAYS	HOURS MIN.	Jun 24, 19	913	OH			
~	Se. FACILITY NAME (If not institution, give str				OR LOCATION OF DE	EATH	9c. COUNTY				
DIRECTOR	Memorial Hospital	& Medical (	enter	Cumbe	rland		Alleg	gany			
EC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY			
	MD Alle	gany	Cur	nberland							
AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	1 X YES 2 □ NO  OF WHAT COUNTRY?			
FUNERAL	1019 Lexington Av	venue			21502		USA				
E	11. MARITAL STATUS  1 Never Merried 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc.			
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 - YES	2 X NO Specify			Specify:			
	15. DECEDENT'S EDUCA	ATION	16a. DECEDENT'S	USUAL OCCUPATION	ON .	16b. KIND OF BUS	SINESS/INCHET	white			
E	(Specify only highest grade c Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of v	vork done during mo se retired.)	st of working						
MP	12		Homema	ker		Own Ho	ome				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meiden	Surneme)				
BE	John Yost				Effie	(Albright	:)				
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town	,	(a)			
.	Ralph V. Hornick					Cumberlar		21502			
	1 Buriel 2 Cremation 3 Remon	val trom State 20b.	PLACE AND DATE OF STREET, Cremetory or of the unset Me	OF DISPOSITION (Na ther place)	me of	06/01 Cur	cation — city				
	21. MONATURE OF FUNERAL SERVICE LICE	INSEE /	unset me		OLK O ADDRESS OF FA		iber rai	na, MD			
	V/ana 7	X/1	-//	Scarp	elli Fun	neral Home					
-	23. PARTAL Enter the diseases, or co	New	PUL	Cumbe	rland, M	ID 21502					
	snock, or neart failure. L	lat only one cause on e	ch line.	ot enter the mo	de of dying, auc	h aa cardlec or respi	ratory arrest,	Interval Between			
	IMMEDIATE CAUSE (Final disease or condition	Acuto Dos		. Fodlam	-			Onset and Death			
1	resulting in death)	Acute Res	CONSEQUENCE OF					3 Weeks			
z		Pneumonia						3 Weeks			
CERTIFICATION	Sequentially list conditions, If any, leading to immediate		CONSEQUENCE OF	7):				J WEEKS			
2	CAUSE (Disease or Injury C.										
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ን፡							
CE	d.										
- 11	PART II. Other algnificant conditions		ut not reaulting i	n the underlying	cause given in	Part I. 24a. WAS AN A PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
200	Meningococcal	Sepsis				1 YES 2		COMPLETION OF CAUSE OF DEATH?			
ME						_		1 _ YES 2 _ NO			
ä	DID TOBACCO USE CONTRI				UNCERTAIN	1 🗆					
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:							
₹ Į	27. MANNER OF DEATH	1 2 inpatient 2 ☐ ER/Outp	28b. TIMI			6 Other (Specify)					
	1 Netural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK?	28d. DESCRIBE HOW IN	JURY OCCURE	D			
BY	2 Accident Investigation 3 Suicide & Could and be	26s. PLACE OF INJURY	— At home, farm, s			26t, LOCATION (Street or	nd Number or Br	urai Bruda Numbar			
Ë	4 Homicide 6 Could not be determined	building, etc. (Speci	ffy)			City or Town, State)	no recincer or re	are route number,			
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowl	edge, death occurre	d at the time state	and place, and thus	to the causele) and man					
MO	29e. CERTIFIER (Check only one)  CERTIFIER (Check one)  CE										
	29b. SIGNATURE AND TITLE OF CERTIFIER	Jr			29c. LICENSE NUM			NED (Month, Day, Year)			
) BE		Anston			D33280			30. 1995			
5		nson Heights	Medical	Print) Buildir	ng Cumbe	erland, Md.					
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNI	ATURE A AR								
	31. DATE FILED (Month, Day, Year)  JUN 0 2 1995	Jalia Davelson	rhandall								



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	signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. F Health and Mental Hygiene prior to burial, cremation, or removal,	
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ate be executed within 154 hours after death. Page 6 may be retained by the hospital or attending physician.	Dera	Ē
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that the death certificate	i signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or rem	we any injury, or other traumatic event, the medical examiner must be notified at once.
E IE	by a	y in
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dife	Sign H	W.S

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THE HOSPITAL ( THE FUNERAL C

TO THE HOSPITA
TO THE FUNERA
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IMPORTANT: I

DIRECTOR: / hours after of item 28 is

HOSPITAL OR ATTENDING PHYSICIAN: The law

CERTIFICATION

MEDICAL

PHYSICIAN:

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1 - STATE STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEAN
REGISTRAR 95 18539 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH CECIL PAGE HERSHBERGER May 31 1995 2:10 7. DATE OF BIRTH (Month, Day, Year)
Nov. 28, 1915 4. SOCIAL SECURITY NUMBER 8. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 X M 2 | F 79 MIN. 220-10-7316 West Virginia 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MEMORIAL HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY WEST VA MINERAL FT. ASHBY 1 X YES 2 NO 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 26719 WASHINGTON STREET 21 U.S.A. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married If yes, specify Cuba Specify: Specify: 3 Widowed 4 Divorced WHITE W.W.II 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete DECEDENT'S USUAL SOCIETY (Give kind of work done during most of workang (Give kind of work done during most of worlang life. Do NOT use retired. CONDUCTOR OF 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 8 +) UNKNOWN RAILROAD O RAILROAD 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CECIL LANTZ HERSHBERGER SUSAN LOGSDON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code IMOGENE WAGONER FT. ASHBY, WV BOX 26 26719 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 20a. METHOD OF DISPOSITION

1 

| Burial 2 | Cremation 3 | Removal from State
| Donation 5 | Other (Specify) | AH BY FT. ASHBY, WV CEMETERY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FT. ASHBY FUNERAL HOME, unchunch P O.BOX 1260-FT. ASHBY, WV 26719 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory erreat, Approximate shock, or heart fellure. List only one cause on each line. Interval Betw Onset end Death **IMMEDIATE CAUSE (Finel** disease or condition 24 Hrs DUE TO (OR AS A CONSEQUENCE OF): resulting in death) CLOSURE OF TRACHEOSTOMY SITE OUE TO (OR AS A CONSEQUENCE OF): 48 Hrs Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reculting in deeth) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DEPRESSION; COPS 1 - YES 2 - NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \$\subseteq\$ NO \$\subseteq\$ UNCERTAIN \$\wideter\$ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 - ER/Outpetient 3 - DOA Ing Home 5 Residence 6 Other (Specify) 27. MANNED OF DEATH 26a. DATE OF INJURY 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Netural M 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide

29s. CERTIFIER

(Check only

1 CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER D 23334

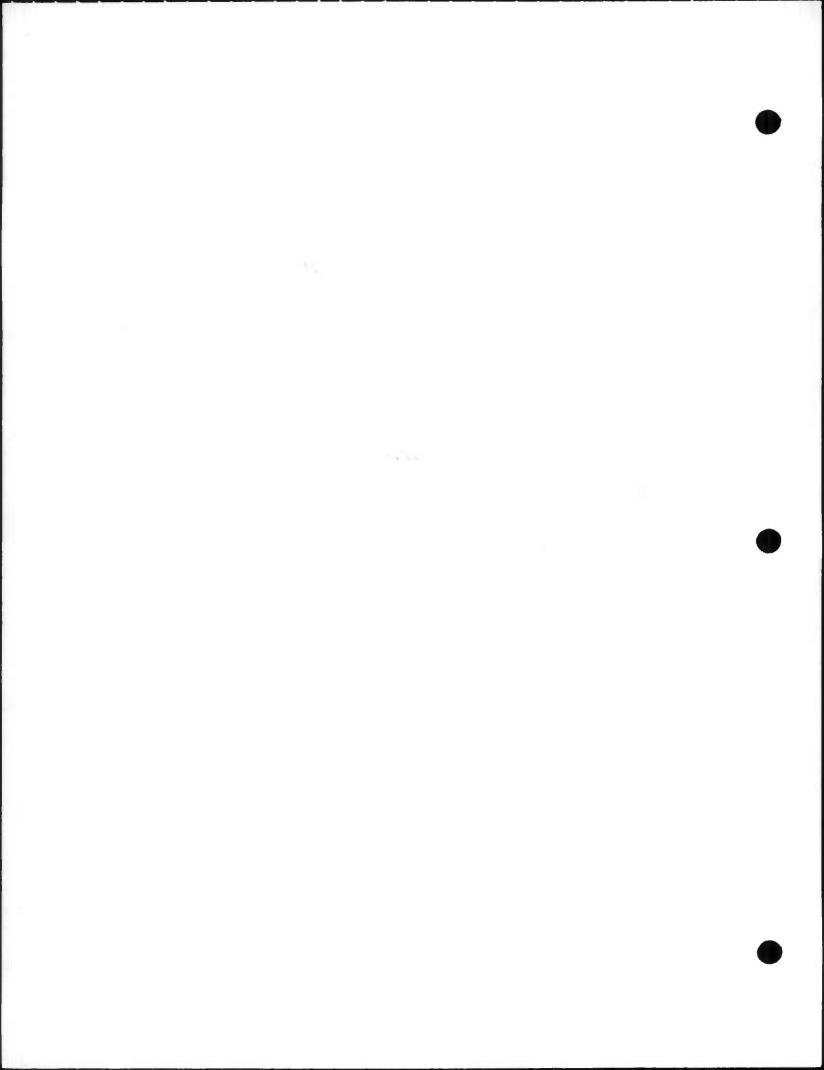
29d, DATE SIGNED (Month, Day, Year) May 31 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATHL(TEM 27) (Type, Print)

Dr. D. Shah, Johnson Heights Medical Bldg., Cumberland, MD 21502

31. DATE FILED (MONTH, DRY, 201) 1995

SZIREGISTRAR SIGNATORE



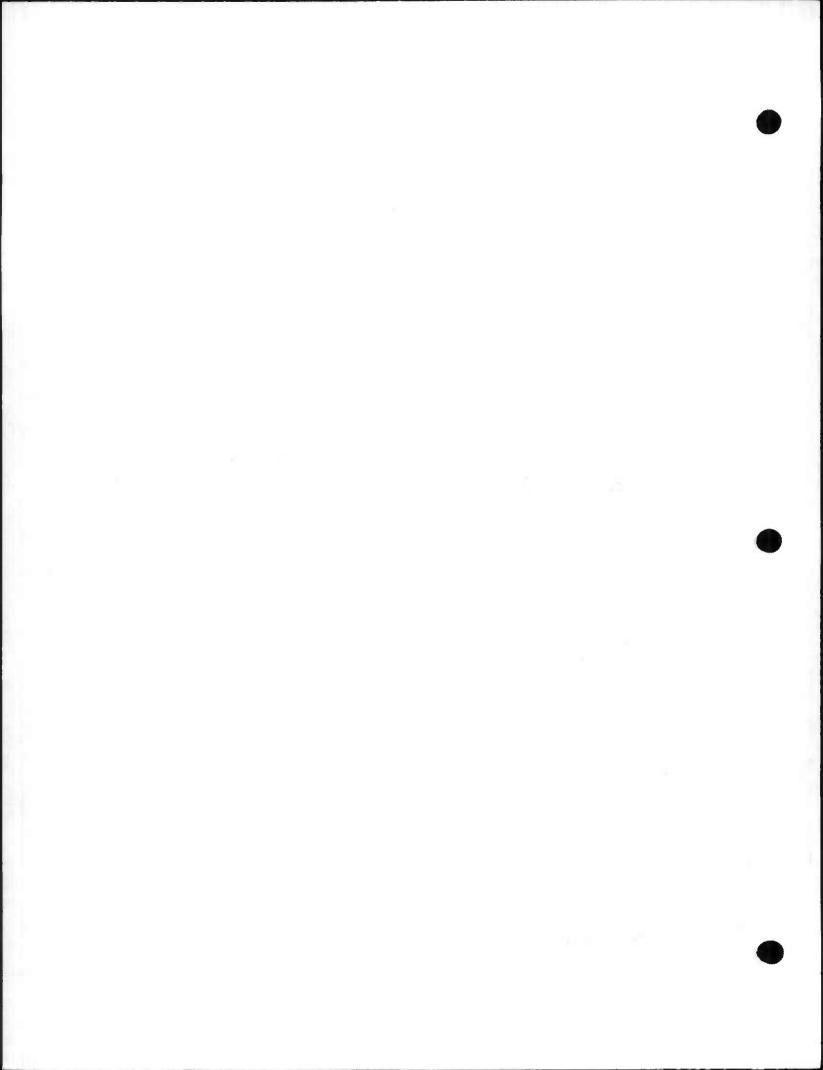
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

G PHYSICIAN: The law requires that the death certificate be executed with him from after death. Page 6 may be retained by the hospital or artending physician,	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	or removal.	medical examiner must be notified at once.
DEPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the	R: After th	where 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	INT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO

- 5	1. OECEDENT'S NAME (First, Middle,	Last)				- 0.	חבת		2. DATE OF DEATN		_	D THE OF DEATH	
	FRANCES	THELMA		HAIN	FC				MONTH DA		YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER	1 YEAR	IF UNDER	24 MBS	MAY 29,	<u> 1995</u>	a Burre	12:02 P M	
	234-54-7590	1 🗆 M 2 👽 F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	1010	Count	ry)	
	9a. FACILITY NAME (If not institution,	Λ.	70	-	ah OlTy	TOMB!	20.0017	ON OF DE	Dec. 25,			aryland	
œ									AIN	9c. COUNTY OF DEATN			
5	Sacred Heart	HOSPITAL			Cı	ımbe	rland	1		Allegany			
DIRECTOR	10a. STATE 10b. CC			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY			
ā	Marvland A	llegany			Rawl	ina					LIMITS? 1 YES 2 Y NO		
4	10e. STREET AND NUMBER	11050117			Mawi		f. ZIP COD	E		10g, CIT	IZEN OF V	WHAT COUNTRY?	
FUNERAL	Rt. 3, Box 9	5					2155	5.7			USA	200, 200, 200	
3	11. MARITAL STATUS	1. MARITAL STATUS 12. WAS DECEDENT EVER IN							IC ORIGIN? (Specify Yes	or No.		E — American Indian,	
	1 Never Merried 2 Married	YES 2 X	(110		1 yes, sp	ecify Cube	n, Mexican Specify.	, Puerto Rican, etc.)	71,014	Blac Spec	k, White, atc.		
BY	3 Widowed 4 Divorced					X	орвону.			apec	White		
COMPLETED	15. DECEOENT'S (Specify only highest	16a. D	ECEDENT'S	USUAL O	CCUPATIO	ON NO.		16b, KIND OF BUS	BINESS/INI	DUSTRY			
91	Elementary/Secondary (0-12)	College (1-4 or 5 c	- 60	e. Do NOT us	e retired.)	Joing Inc	ISC UI WUTKII	70					
MP	8	I	lomema	aker				Own	n Hon	ne			
8	17. FATHER'S NAME (First, Middle, Las	*					18. MOT	HER'S NAM	AE (First, Middle, Maiden	Surneme)			
BE	Henry Twig	g					Et	chel	M. Blaze	edale	2	- 17	
2	19e. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADORESS	(Street e	nd Number	or Rural A	oute Number, City or Town	n, State, Zij	Code)		
-	Paul A. Haine	<u>s</u>		Rt.	3, B	ox !	95 F	Rawli	ngs, MD 2	21557	,		
	20e. METHOD OF DISPOSITION 1 V Burlel 2 Cremetion 3	Removal from State		AND DATE (		ITION (Na	ime of		DATE 20c. LO	CATION -	City or To	own, State	
	4 Donation 8 Dother (Specify)					ter	y Ji	ine 1	. 1995 Ro	mnev	. WV		
H	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE						SS OF FAC					
	1 Amur	Double	6	Rotruck-Smith Funeral Home							0.670.6		
	23. PART i. Enter the diseases,	or complications the	ceused the d	leath. Do r	ath. Do not enter the mode of dying, such as cardiec or respiratory errest							26726	
l	shock, or heart fall	ure. List only one cau	se on each lin	e.								interval Between Onset and Daath	
Ì	disease or condition	Ro	cline	1			O.	0	0 (00	6	(	Unset and Daath	
	resulting in death)	DUE TO	OR AS A CONSE	Atom y Jackure (acuse) 2 dog af lune with Ketastari 5 mi						2001			
z I		- Can	cer	of lune with Ketastaris 5							5 marse		
일세	Sequentially list conditions, if any, leading to immediate			DISEQUENCE OF):							J mous		
<u>১</u>	CAUSE (Disease or injury	a Se	bere		0	Y	0 -					7/07 cm	
	that initiated events	DUE TO	OR AS A CONSE	QUENCE OF	1:								
CERTIFICATION	reaulting in death) LAST	d											
п	PART ii. Other significant cond	itions contributing to	death but not	resulting i	n the un	derlying	T COURS C	alven in E	Part i. 24a. WAS AN	ALLEDODON	1.00	. WERE AUTOPSY FINDINGS	
EDICAL						our yang	9 00000 9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR		240	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
									1 TYES 2	NO.		OF DEATH?	
≥ ∥	DID TOPACCO LISE CO	AITDIDLITE TO CA	UCE OF DE	ATLL ME	c III s	10 [	1					1 YES 2 NO	
A N	DID TOBACCO USE CO			CE OF DEAT			JUNC	ERTAIN					
ᄗ	EXAMINER?	HOSPITAL:			OTHER	t:							
PHYSICIAN:	27. MANNER OF DEATH	1 Inpatient 2 28e. DATE OF		28b. TIM		28c. INJ			Other (Specify)	1 11 1501 0 0	011000		
- 40	1 Natural 5 Pending	(Month, De			URY	WO	RK?		28d. DESCRIBE HOW IN	DUNT OC	CUMED		
à l	2 Accident Investigat 3 Sutcide 8 Could be	28a PLACE OF	FINJURY — At h	ome, ferm, s	treet. facto			-	281. LOCATION (Street a	ad Mumbu	or Pount C	Pouto Alumbas	
	4 Homicide 8 Could no determine	ounding.	etc. (Specify)		,	,			City or Town, Stete)	INC THURSDAY	OF HOTEL	node Number,	
9	29e. CERTIFIER	HVDICIAN To the best of				_	_						
COMPLETED		HYSICIAN: To the best of MINER: On the bests of ex											
ဗ ူ				investigatio	n, in my o	pinion, u	eath occur	ed at the t	ime, date end place, end	due to th	e ceuse(s	) end manner ee stated.	
8	296. SIGNATURE AND TITLE OF CERT	Toll-	6	200	6		29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)	
2	TO MANUEL OF THE PARTY OF THE P	anai	rna	16	2		0-	7)	6	MA	<u> </u>	0 1995	
	30. NAME AND ADDRESS OF PERSON			1	1000								
ŀ	DR. JOHN MEHA	NNA, M.D.,	909 B S	SETON	DRIV	Æ.	CUMB	ERLA	ND. MD 215	02			
	JUN 0 2 1995	7000	CON KANDAL	ζ									
		7											

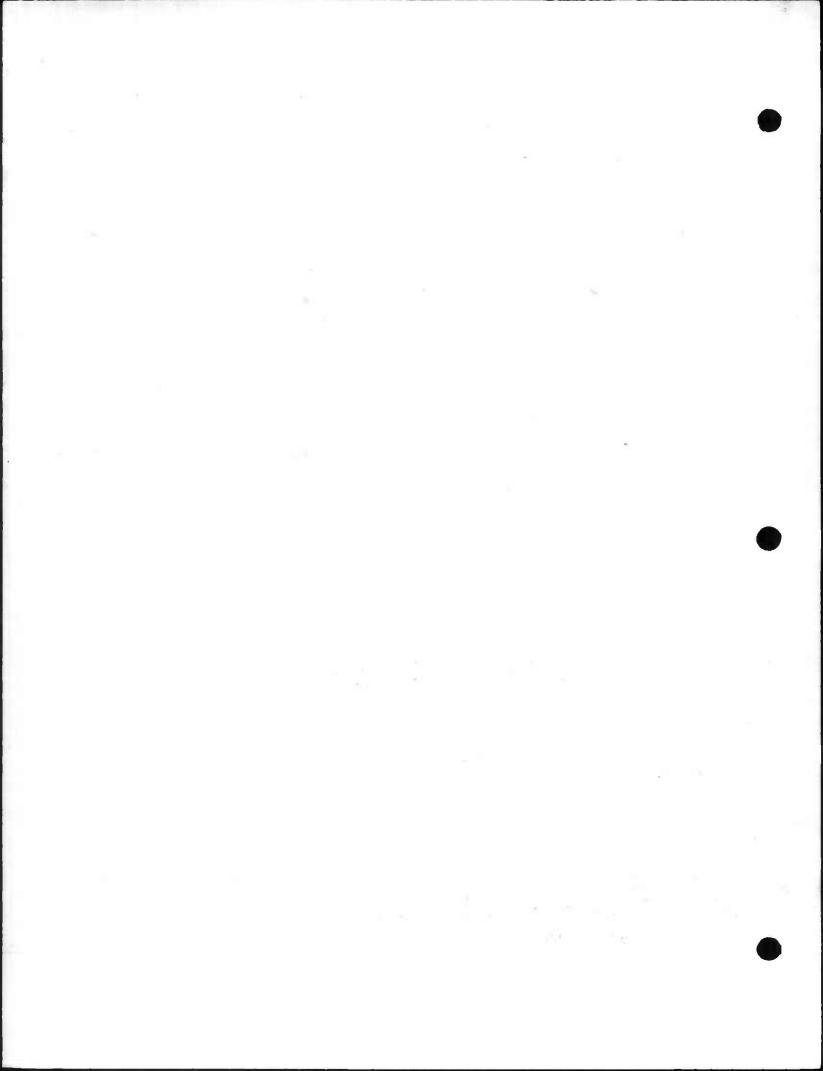


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MADRITANT: If Item 28 is marked or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be mailtied at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
CERTIFICATE OF DEATH		REG. NO.

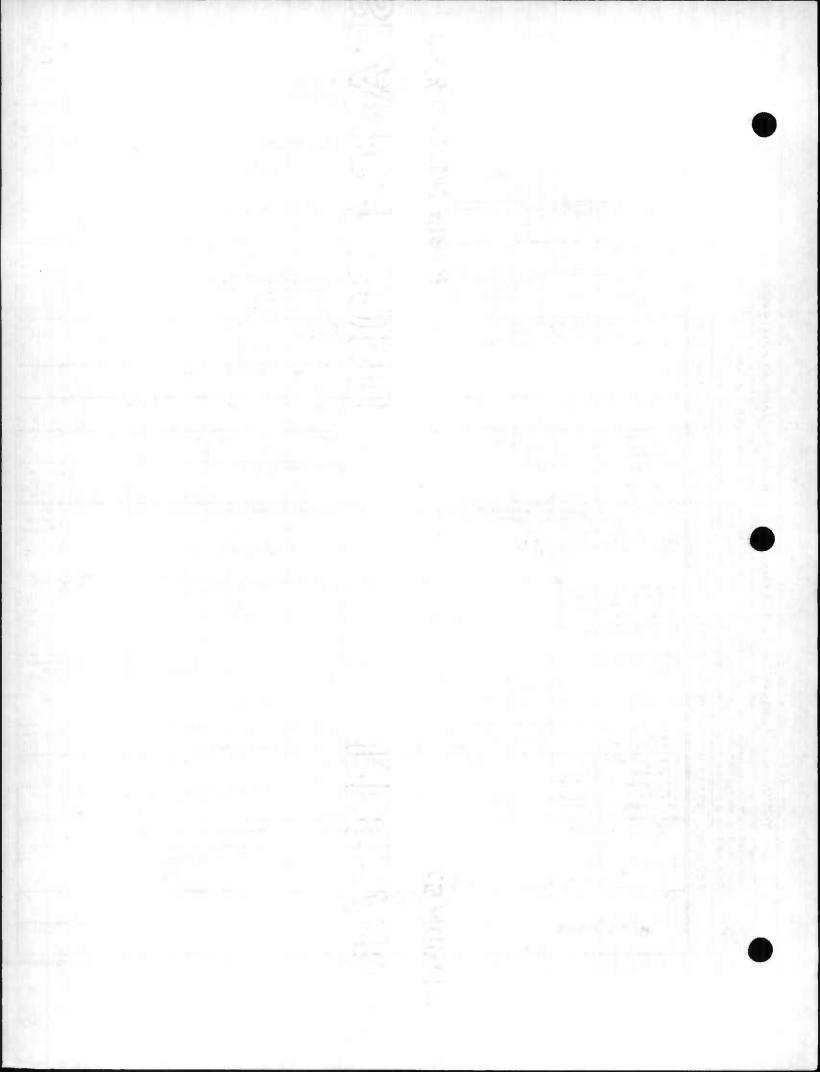
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM	ENT OF H	EALTH AND I	MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF OEATH		3. TIME OF DEATH
	STACY Lewis	HAMMER				MAY 22	199	5 11:20 A M
		S. SEX 6. AGE (In yrs.	8600	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give stree	M 2 0 F 90	YRS.			Sept. 28,1		NUSYlvania
DIRECTOR	Homewood Retir				HSPONT		Was	hington
1 2	10a. STATE 10b. COUNTY			OWN OR LOCATI				10d, INSIDE CITY
		ington	Wil	liams	port			LIMITS?
FUNERAL	10e. STREET AND NUMBER	1 10			ZIP CODE		_	OF WHAT COUNTRY?
N N	16505 Virgin				21795			SH
	1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2		If yes, spe	cify Cuban, Maxica	NC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No 14.	RACE — American Indian, Black, Whita, atc.
B	3 Widowed 4 Divorced	IF YES, OIVE WAR OR DATES		1 TYES	2 NO Specify	c.		Specify: White
ED ED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	DECEDENT'S USU (Give kind of work	done during mos	N t of worldna	16b. KIND OF BUS	INESS/INDUST	TRY .
Ë		Callege (1-4 or 5+)	life. Do NOT use ret	lired.)		-	- /	
COMPLET	17. FATHER'S NAME (First, Middle, Last)	S	uperint	<u>endent</u>			reel	
E 111	OLIVER Hamm	ior				ME (First, Middle, Maiden Louise B	1	
TO BE	19a, INFORMANT'S NAME (Type/Print)		196. MAILINO ADD	DRESS (Street an		Poute Number, City or Town		de)
1	Dorothea Hame	1er	16505	Va. Av	remue 0	villiamspo	Mr. Mu	d. 21795
must be	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remove	20b. PLAC	E AND DATE OF DE	SPOSITION (Nan	ne of	DATE 20c. LO	CATION - City	or Town, Stata
Ē	4 Donation 5 Other (Specify)	Rest	Naven		ory (	8953- Fred	derick	Manyland
examiner	21. SIGNATURE OF FUNERAL SERVICE LICEN  Emast a.	SEE D' A			ADDRESS OF FAI	Inc. 230		
				Cumbe	erland. M	ld. 21502		
Деогра	23. PART I. Enter the diseeses, or com shock, or heert feliure. Lis	nplications that caused the of the only one cause on each lie	death. Do not e	enter the mod	e of dying, sucl	as cerdiac or reapi	ratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition			-				Onset and Death
Ě	resulting in deeth) a	-/ NOV	noh	14				6 weeks
2		DUE TO (OH AS W CONS	EQUENCE OF):					
	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF):					
S	cause, Enter UNDERLYING CAUSE (Disease or injury							
	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONS	EOUENCE OF):					
CERTIFICATION	d							
A P	PART II. Other aignificant conditions of	ontributing to death but not	resulting in th	e underlying	ceuse/given in	Part i. 24s. WAS AN A		24b. WERE AUTOPSY FINDINGS
	10 hotel Vas	We delled	e	Dene	a Xa	1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEC	Hart lode.	HUMENE	25104			_		1 TYES 2 NO
PHYSICIAN: M	DID TOBACCO USE CONTRIB		ATH YES [	□ NO 🗗	UNCERTAIN	1 🗆		
<u> </u>		OSPITAL:	ACE OF DEATH (C	heck only one) HER:				
HYS	1 YES 2 NO 1	□ Inpatient 2 □ ER/Outpatient 28s. DATE OF INJURY	3 DOA 47	Nursing Home 28c. INJU		8 Other (Specify)	HIM CARLE	
E	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOR	K?	28d. DEŞCRIBE HOW IN	JURY OCCURE	:0
BY BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY — At I	home, farm, atreet			28f. LOCATION (Street a	nd Number or R	ural Route Number,
COMPLETED	4 Homicide determined	building, etc. (Specify)				City or Town, State)		
PLE	29a. CERTIFIER (Check only	N: To the best of my knowledge, o	death occurred at	the time, data a	nd place, and due	to the cause(a) and man-	ner as stated.	
ON O		or the basis of examination and/o						use(a) and menner as stated.
BE C	29b. SIGNATURE AND TITLE OF SERVIFIE	)			29c LICENSE NUM	BER	29d. DATE SIG	ONED (Month) Day Ham
TOE					19468	60	D 5	12471
	30. NAME AND ADDRESS OF PERSON WHO O	OMPLETED CAUSE OF DEATH (IT	EM 27 (Type, Print	He	spoke	The M	) ZI	742
	31. DATE FILED (MOATH, Day, Year) MAY 3 V 1995	32 AGGISTHAR'S SIGNATURE	ardall		)			



	t. DECEDENT'S NAME																			
- !				II.e	2 2 2 2 2 2				Mon Ma	E OF DEATH	o, 19	95	3. TIME OF DEAT 5:45							
	Edith		ott Is. sex		enry				_											
	216-74-		1 M 2 F	6. AGE (In yrs. 85	YRS.	IF UNDER MONTHS	DAYS	HOURS MIN.	(Mor	E OF BIRTH oth, Day, Year)	190		PLACE (State or For							
	9a. FACILITY NAME (III	not institution, give	street and number)			9b. CITY,	, TOWN		9c. COUNTY OF DEATN											
DIRECTOR	Egle Nu	rsing	Home, Ir	ic.		Lo	nac	oning			All	egan	y							
ឆ្ន	10a. STATE	10b. COUN		1.00	10c, CIT	Y, TOWN C	OR LOCA	TION					10d INSIDE CITY							
E I	Maryland	Δ11	egany			onaco					Home  Maken Surmame)  Eyre  Chy or Town, State, Zip Code)  Timonium, Má 210  20c. Location — City or Town, State  Westernport, Má.									
	10e. STREET AND NUM		egaity		11(	maco	_	M. ZIP CODE												
FUNERAL	7 Furn	ace St.						21539												
ž	11. MARITAL STATUS	iace De.	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. 1	WAS DE		NIC ORIG	IN? (Specify Ye	a or No-		— American India							
B	1 Never Married : 3 Widowed 4		FORCES? 1 IF YES, GIVE W			- 1	If yes, sp	pecify Cuben, Maxic 3 2 NO Speci	an, Puarto			Black	y:							
	15.	DECEDENT'S ED	UCATION	16a.	DECEDENT'S				16	b. KIND OF BU	SINESS/IND	USTRY								
Fi	Elementary/Seconds		College (1-4 or 6+	)	Me. Do NOT us	se retired.)	aunng m	ost of working												
COMPLET	Unknown			3	Homema	ker				Ho	me									
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w II	John S	cott							J	Intyre										
10 B	19s. INFORMANT'S NAI										vn, Stata, Zip	Code)								
F	Maryl	еа Н	Miller		44	East	t T	imonium	Rd	. , 1	imon	ium.	Md 21							
	20a METHOD OF DISP	OSITION	movel from State	20b. PLA	CEANDDATE	OF DISPOS	SITION (N	ama of	DA											
	4 Donation 6 0			Ph	IIOS C	emet	ery			We	stern	port	, No.							
								21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY BOAL FUNERAL HOME												
	21. SIGNATURE OF FUN	NERAL SERVICE L	JCENSEE	0		22.														
	23. PART I. Enter th	ha dispusea, or or heart fallure	complications that List only one ceu	Cerel	death. Do i	not anter	Boal 111 the mo	l Funera	Hor	Western rdlac or reap	pport	NG.	Approximatintarval But Onset and 3 day							
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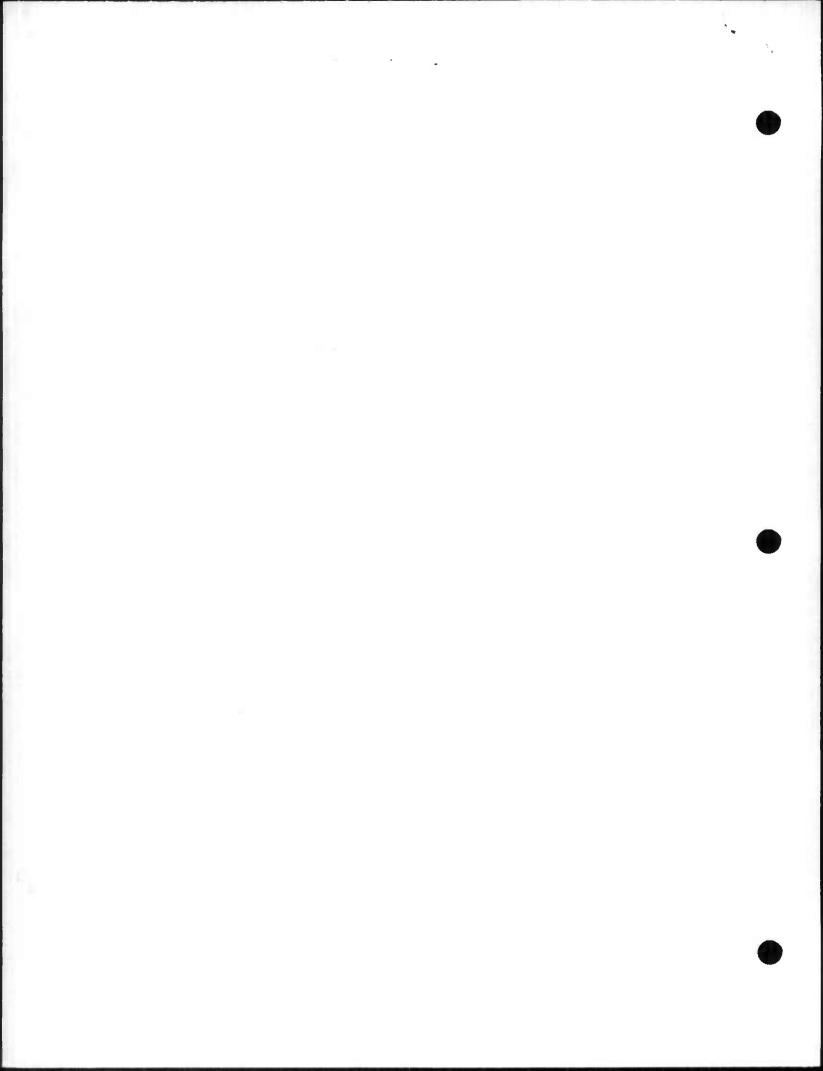
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



FOR

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART				G. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	EATH DAY	YEAR	3. TIME OF DEATH				
	AVERY	W.			ERSOIL	June		1995	1800)				
	4. SOCIAL SECURITY NUMBER			NTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIL (Month, Day.	RTH Year)	8. BIRTHE Country	LACE (State or Foreign				
	577-09-8237  9a. FACILITY NAME (If not institution, give		32 YRS.		OR LOCATION OF D	3-19		Mai	cyland				
DIRECTOR	PENINSULA REGIO				LISBURY	LAIR		ILCOMI					
3EC	10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCAT	TION				10d. INSIDE CITY				
	Md.	Worcester			G	irdlet	ree		LIMITS?				
ERAL	10e. STREET AND NUMBER			101	. ZIP CODE			TIZEN OF WI	HAT COUNTRY?				
VER	P.O. Box 74				2182	29		U.S.	. A .				
FUN	11. MARITAL STATUS  1 Never Married 2X Merried	12. WAS DECEDENT EVER IN U	J.S. ARMED		ENDENT OF HISPA			14. RACE Black.	- American Indian, White, atc.				
В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES		2 X NO Specif			Specify					
	15. DECEDENT'S EDU		6a. DECEDENT'S US	UAL OCCUPATION	ON	16h KIND	OF BUSINESS/IN	INIETRY	white				
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of worlden. Do NOT use to	k done during mo etired.)	st of working								
APL	11		Trapper	c & ≥₩₽	f-Emp.	Se	afood	Indus	stry				
COMP	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle,	Meiden Surname)						
BE (	William W. I	ngersoll			Annie	e Puse	y Inge	rsoli	l				
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural								
-	Mary P. Inge	rsoll	P.O.	Box 7	4, Giro	dletre	e, Md.	2182	29				
	20e. METHOD OF DISPOSITION 1 [XBuriel 2 Cremation 3 Rem	20b. P	LACEAND DATE OF	DISPOSITION (Na	ume of	1	20c. LOCATION -	•					
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LI		or inghi			6/3	Girdl	etre	e,Md.				
	Patricia	L. Don	nis		is Fune		ome, S	now I	Hill,Md.				
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximation of the cause of the ca												
	iMMEDIATE CAUSE (Final disease or condition	0							Onset and De				
	reaulting in death)	. Preum							Weeks				
		DUE TO (OR AS A C											
CATION	Sequentially list conditions, if any, leading to immediate	b. Head of		ch c	ancer				month				
CAT	cause. Enter UNDERLYING	•	Charles Ave. 10.						į				
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):						1				
CERTIFIC	resulting in death) LAST	d											
	PART ii. Other significant condition	as contributing to death but	not resulting in	the underlying	r cause alven in	Part I Dan I	WAS AN AUTOPSY		VERE AUTOPSY FINDIN				
CAL					given ui	1 '	PERFORMED?	1	WAILABLE PRIOR TO				
MEDIC						_   10	YES 2 NO		OF DEATH?				
	DID TOBACCO USE CONT	RIBLITE TO CAUSE OF	DEATH YES	ПИОГ	UNCERTAIL	N F		1	YES 2 NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		OITCERIAII								
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpati		THER:	e 5 🗆 Residence	6 C Other (Spec	-/fv1						
ξ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c. INJ	URY AT		HOW INJURY OF	CCURED					
ВУ	1 Natural 5 Pending 2 Accident Investigation	(month, bay, rour)	INJOH		RK? /ES 2 NO								
8	3 Suicide 8 Could not be	28s. PLACE OF INJURY — building, etc. (Specify	At home, ferm, atre	et, factory, office		28f. LOCATION City or Town	(Street and Number State)	or Rural Ro	ute Number,				
	4 Homicide datarmined					Ony or Now	i, otelo)						
7	290. CERTIFIER (Check only	ICIAN: To the best of my knowled	ge, death occurred a	it the time, data	end place, end due	to the cause(s) a	and manner as st	nted.					
COMPL		R: On the beals of examination a							and manner as stated				
ш	29b. SIGNATURE AND TITLE OF CERTIFIE		2000		29c. LICENSE NUI	MBER	29d, DA	TE SIGNED (	Month, Day, Year)				
00	30	you pan	1111)		D417	21	•	6/2/0	35				
일	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Pri	nt)	, .			++-					
5	STEPHAN PAULOS	560 RIVERSI	de DR.	B101	SALISBU	iny Ma	1. 2180	01					
/	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URF	ALC: NO PERSONS ASSESSMENT		1							



ITEMS: 23 PART I. PER MED FILM G-726 8/10/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

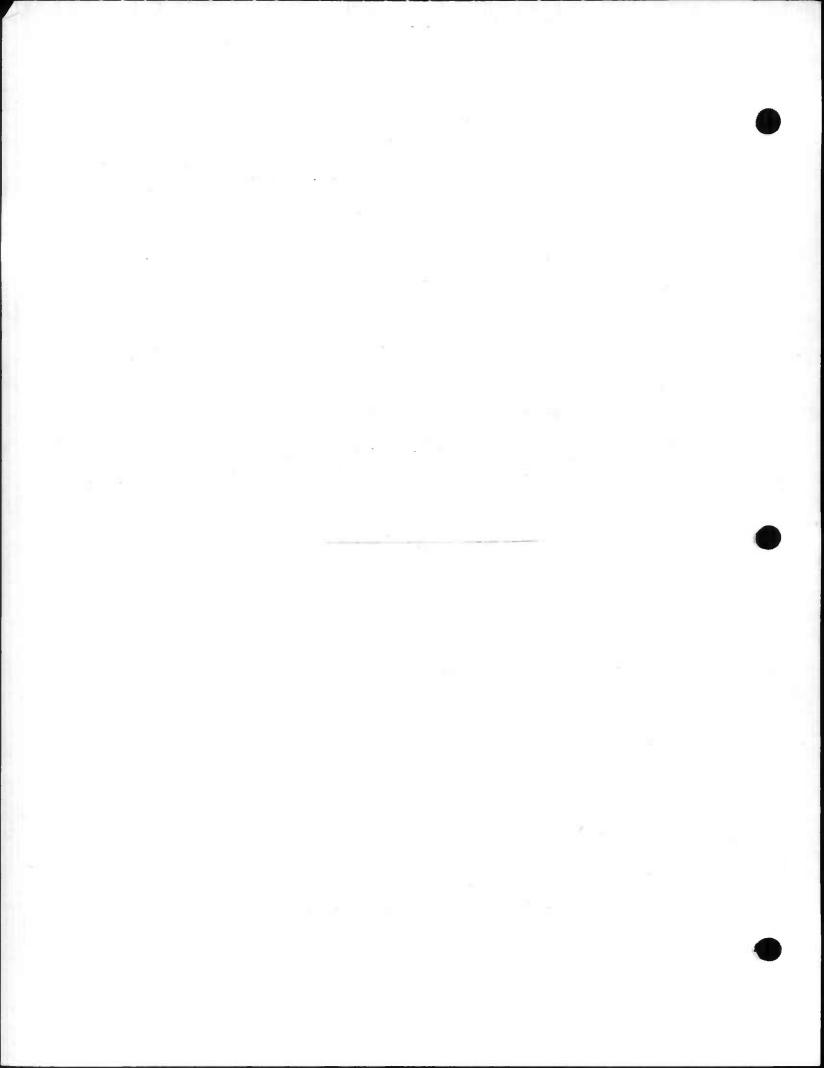
FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATH 1995 KENNETH IMOISLI MAY 21 0320 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign HOURS 217-33-7751 1 St M 2 🗌 I 35 YRS. APRIL 30 1960 NIGERIA permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATN ST. AGNES HOSPITAL CITY BALTIMORE DIRECTOR N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. IHSIDE CITY BALTIMORE MD N/A 1 YES 2 | NO 10a. STREET AND HUMBER FUNERAL 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 9100 ABIGAIL DRIVE #3C 21237 NIGERIA retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF NISPAHIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 ZI NO Specify: 1 Never Married 2 Married BY Specify 3 Widowed 4 Divorced BLACK COMPLETED 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIHD OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) DOCTOR BAYVIEW MEDICAL CENTER 4 17. FATHER'S NAME /First Mickelle Leat) 16. MOTHER'S NAME (First, Middle, Malden Surname) Ħ JOHN IMOISLI UNAVAILABLE BE notified 19e. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 13004 COTTAGE FIELD LANE, GERMANTOWN, MD 20874 CHRISTOPHER AYCWOH hours after death. Page 6 may be pe 20e. METNOD OF DISPOSITION
1. Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of camellary, clematory of other place) 20c. LOCATION - City or Town, State OATE must 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) MAY27 95 BALTIMORE, MD examiner 21. SIGNATURE OF FUHERAL SERVICE LICENSEE W.H. BACON FUNERAL HOME INC. saci 276 3447 14TH STREET, N.W. WASH, D.C. 20010 attending physician and completely filled in by the mal Hygiene prior to burial, cremation, or removal. the medical 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line Interval Between VENTRICULAR DYSPLASIA WITH FOCAL AREAS OF MYOCARDITIS IMMEDIATE CAUSE (Finel Onset and Death disesse or condition resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in desth) LAST 6 signed by the atte Health and Mental PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY shows any 1 YES 2 HO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) OR ATTENDING PHYSICIAN: XXYES 2 NO 1 Inpetient 2 ER/Outpetient 3 I DOA 27. MAHHER OF DEATH 28b. TIME OF INJURY 28c. IHJURY AT WORK? this c 28e, DATE OF INJURY 28d, DESCRIBE NOW INJURY OCCURED marked, Ivatoral 2 Accident 5 Pending 1 YES 2 HO BY After death 28a. PLACE OF IHJURY — At home, ferm, atreet, fectory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 40 ETED. 6 Could not be DIRECTOR: A 4 🗌 Homicide 28 datermined 29a. CERTIFIER 1 CERTIFYIHO PNYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL TO THE POSPHINE.

TO THE FUNERAL D

DE filed within 72 h

IMPORTANT: If It (Check only one) 2 XMEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE HUMBER BE 29d. DATE SIGHED (Month, Day, Year) O.C.M.E ▶ MAY 21,1995 2 30. NAME AHD AGORESS OF PERSON CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 26 1995 davidson Rardall



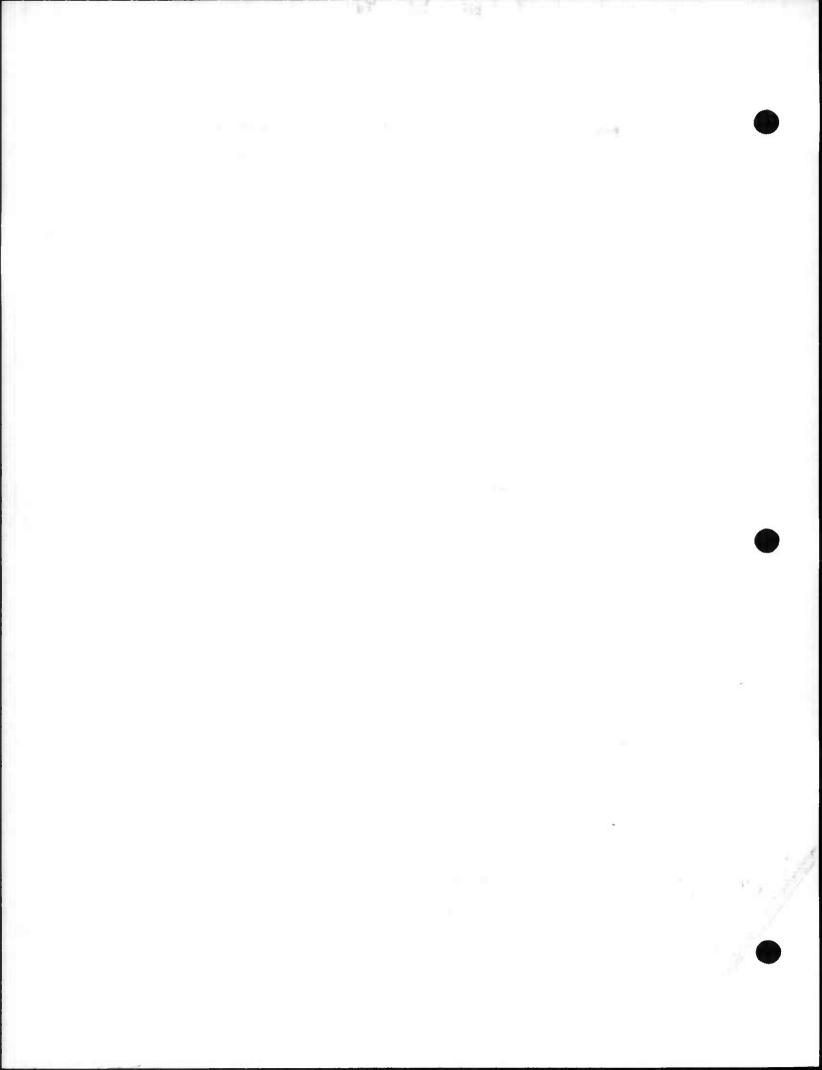
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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		1. DECEDENT'S NAME (First	il, Middle, Last)			JA	COBS					2. DATE	TH29, 19	795	YEAR	3. TIME OF D	
		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE	(In yrs. lest b		IF UNDER	1 YEAR	IF UNDER	24 HRS.	_	OF BIRTH		a BIRTH	6:04 PLACE (State o	- 404
		578-40-7467		1 🗆 M 2 💢 F	1 1511	84		MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Year) - 2 0 -	11	Countr	y)	roreign
3 should		9a. FACILITY NAME (If not		street and number)		- 0 -		9b. CITY	TOWN	OR LOCATI	ON OF DE				NTY OF D	YORK	
2,3	OR	MONTGOMER	Y GENE	RAL HOSPI	TAL			OL	NEY					MON	TGOM	ERY	
←*	ЕСТОВ	RESIDENCE OF DE	10b. COUNT	Y			10c. CITY,	TOWN C	n Loca	TION							
Pages	DIRI	MARYLAND		ONTGOMERY	7	- 1				PRIN(	2					10d. INSIDE C	
emit.		10e. STREET AND NUMBER		JIVI O O I I DI I					-	r. ZIP COD				10a CIT	ZEN OF V	1 YES 2	-
. ig	ERAL	14508 HOME	CREST	ROAD #32	8					V. 12117							
physician. burtal-transit permit.	FUNE	11. MARITAL STATUS	OILLIDI	12. WAS DECEDED	IT EVER IN	N U.S. ARMI	20906  MED 13. WAS DECENDENT OF HISPA							14. RACE	STATES - American I	ndlen,	
	BY F	1 Never Married 2 3 Widowed 4 Div		FORCES? 1 TYES 2 TYES IF YES, GIVE WAR OR DATES						pecify Cube S 2 X NO			Rican, atc.)		Speci	t, White, atc.	
attending se as the			CEDENT'S EDL			B										WHITE	
5	ETE	(Specify on	ly highest grade	completed)		(Give	EDENT'S U kind of wo to NOT usa	vrk done o	during me	ION ost of workin	ng	166	b. KIND OF BUS	INESS/IND	DUSTRY		
- P	PLE	Elementary/Secondary (	0-12)	Collega (1-4 or 5	+)		OMEM		)				OTTAL	IIOME			
the hospital detached fo once.	COMPL	17. FATHER'S NAME (First, A			11	OFILE	AKEI		18. MOT	HER'S NA	ME (First,	OWN Middle, Malden					
क दे द	ш	SAMUEL LOT	SAMUEL LOTENBERG							ANN	E FR	EEMA	N				
5 should be notified at	0	19a. INFORMANT'S NAME (Type/Print)					MAILING A	ODRESS	(Street				nber, City or Town	, State, Zip	Code)		
y be re sage 5	-		ROSE TABB (DAUGHTER)					HAN	IMON	TON	ROAD	SIL	VER SP	RING	_MD	20904	
leath, Page 5 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSIT	on 3 Rem	ovat from Stata		PLACE AN	DDATEOF	DISPOS				DAT		CATION —			
Page 5 Il direct		4 Donation 8 Othe		OEWOOR		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	1100		EAN		5-3	1- OLN	EY. N	<b>IARYI</b>	AND	
death. Pag tuneral di I. examiner		10	O -	19	1			DA	NZA NZA	NSKY-	GOL:	CILITY DBER	G MEMO	RIAL	CHAI	PELS. 1	NC.
the fu		1000	en		ريد	mer	-	11	.70	ROCK	VILL:	E PI	KE-ROC	KVILI	E. N		
hours after death. ed in by the funera or removal. medical exami		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, ahock, or heart feliure. List only one cause on each line.  Approximate interval Between															
filled on or or		iMMEDIATE CAUSE (Fi	mai												_		and Desth
		resulting in death)	<b>→</b>	. ACU	TE	14	400	CA	RD.	CAL	[.	NE	+RC7	101	]	5M	NUTE
			_	b. COR	(OR AS A	CONSEQU	ENCE OF):	1 77	7-1		. 1	Du	. 4. 0	0:	-		
8 " 0 5	CATION	Sequentielly list condi- if any, lesding to imme	tiona,	b. OUE TO	(OR AS A	CONSEQU	ENCE OF):	TIC	10	TU	1	LDU	meso	147		LODG	FINITE
physician pe prior to the traus		cause. Enter UNDERLY	ING	. CON	ON	Are	1 1	47	THE	105	CL	ER	osis			INIG	TULT
ing phy giene p	RTIF	CAUSE (Disease or injustrational initiated svents		DUE TO	(OR AS A	CONSEQU	NCE OF):			10			3				
end H H)	CER	resulting in death) LAST															
E 5 8 6		PART II. Other signific	ent condition	ns contributing to	deeth b	ut not rea	uiting in	the un	deriyin	g cause g	given in	Part i.	24a, WAS AN	AUTOPSY	24b.	WERE AUTOPS	r FINDINGS
mat med by the and land land land land land land land	EDICAL	NON											PERFOR			AVAILABLE PRICOMPLETION D	OR TO
urres ma signed Health a <b>ows am</b> )	MED		84										1 TYES 2	J NO		OF DEATH?	- NO
Sicians: The law requirection of the State Dept. of 1, or Hem 23 sho		DID TOBACCO U	JSE CONT	RIBUTE TO CA	USE O	F DEATH	H YES	1 🗆	10 P	¶ UNC	ERTAIN	V D				1 129 2	_ 140
ficate has be State Dept.	SICIAN:	25. WAS CASE REFERRED 1 EXAMINER?				26. PLACE	OF DEATH	(Check o	only one)								
or He	YSIG	1 YES 2 NO		HOSPITAL:	ER/Outp	etlant 3 🗆		OTHER Num		ne 5 🗆 Re	aldenca	8 🗆 Othe	er (Specify)				
this certifical with the St.	PHY	27. MANNER OF DEATH	0	28a. DATE OF (Month, D		1	28b. TIME			JURY AT		28d. DE	SCRIBE HOW IN	JURY OCC	CUREO		
After this c death with marked,	BY	1 Natural 5 2 Accident	Pending Investigation					М	1 🔲		NO						
ALLENDING ECTOR: After s after death 1 28 Is ma	B	3 Suicide 8 4 Homicide	Could not be determined	28a. PLACE C building,	atc. (Spec	— At home	, term, etr	eet, facto	ory, offic	on .		28t. LOC	or Town, State)	nd Number	or Rural R	oute Number,	
DIRECTOR: After hours after death item 28 is ma	- 1	29a. CERTIFIER															
3 3 R =	COMPLE	(Check only		ICIAN: To the best of													
TO THE HUSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II	8			R: On the besis of a	ABITITIBLIO	n and/or inv	estigation,	in my o	pinion, d	sestn occur	ed at the	time, deta	a and place, and	due to th	e cause(a)	and manner a	a stated.
世	8	29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)									ar)						
268	2	30 NAME AND ADDRESS O	F PERSON WH	O COMPLETED CALL	SE OF DE	ATH /ITEM 3	A Cima D	mine)		100	774	7.7		-3	13	0/95	
		30-MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  LAWRENCE D. MARCH M.D. 10313 GEORGIA AVO. SCLVER SPRING M.D.  31. DATE FILED (Month, Day, Year)  MAY 31 1995 June d'auxiliant Narialle  20902															
	1	31. DATE FILED (Month, Day,	Ybar)	72 REDISTRA		STURP #	100		46	JU ICE	ict i	0700	رالمار	101	311	any.	NEW
- 1	1	MAY 31	1995	your daw	MADK- IV	work.										2016	) 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALIIMOR	burs after death. Page 6 ma	Thing in by the funeral director, poor, or removal.	he medical examiner must
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed will	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely mind in by the funeral director, is be fled within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, gremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must

31. DATE FILEDJUN 2

	1. DECEDENT'S NAME (Firs	st, Middle, Last)					E OF			2. DATE	OF DEATH	AY	WEAR	3. TIME OF DEATH
		Baby	Girl	Jen	kins					Feb.		1995	YEAR	02:20 p.
	4. SOCIAL SECURITY NUM N/A	IBER	5. SEX 1 ☐ M 2 🔯 F	6. AGE (In yrs. le	st birthday) YRS,	IF UNDE	DAYS	HOURS	MIN.	7. DATE ( (Month	TE OF BIRTH onth, Day, Year)		Coun	HPLACE (State or Foreign stry)
	Se. FACILITY NAME (If not it	institution, give st	reet and number)		9b. CITY, TOWN OR LOCATION OF DEATH						0. 04, 1995 Maryland			
5	Washingt	ton Ad		Hospit	al			oma I			Montgomery			
DIRECTOR	10a. STATE MD	10b. COUNTY	ce Georg	00	10c. CITY, TOWN OR LOCATION Hyattsville									10d. INSIDE CITY LIMITS?
	8											1 X YES 2 NO		
	6103 - 42	2nd Ave	nue #B	-302				207	7			log. or	US.	
DI LUNERAL	11. MARITAL STATUS 1 Never Married 2  3 Widowed 4 Div		12. WAS DECEDEN FORCES? 1 IF YES, GIVE Y	YES 2 X		13.	If yes, sp	ENDENT C	OF HISPAN	in, Puerto F	? (Specify Yes	s or No—	14. RAC Blac	CE - American Indian, ock, Whita, atc.
	15. DE	CEDENT'S EDUC	CATION	16a, D	ECEDENT'S	USUAL	OCCUPATIO	ON.	-	166	KIND OF BU	CINECCHNI	DUSTRY	
COMPLETE	(Specify on Elementary/Secondary (	nly highest grade (0-12)	College (1-4 or 5	((	Sive kind of Do NOT u	work done se retired.)	during mo		79	100.	KIND OF BO	N/		
5	17. FATHER'S NAME (First, A	Middle, Lest)	M/A		14 / 1			16 MOT	UCO'C NA	ME (First A	fiddle, Maiden		11	
5		Unknow	n						hery		Jenki:			
ا ۵	19a. INFORMANT'S NAME (	(Type/Print)		16	b. MAILING	ADDRES	S (Street a				er, City or Tou		n Codel	
2	Suseela Drumheller 7600 Carroll Ave., Takoma Park, MD 20912													
	20a. METHOD OF DISPOSIT	TION	146	20b. PLACE	AND DATE	OF DISPO	SITION (Na	me of		DATE		CATION -		
	1 Burial 2 N Cremati- 4 Donation 5 Othe		oval from State	cemetery.cr Washi	ngtory or o	ther place	vent	ist H	losp.	195	Take	oma P	ark	, MD 2091:
	21. SIGNATURE OF FUNERA	AL SERVICE LIC	HASE LACO	ha		22	NAME AN	ing to	SS OF FA	Adven	tist	Hosp	ita	1
4	7600 Carroll Avenue, Takoma Park, MD 20													
- 1	Approximate interval Between Onset and Death  Approximate interval Between Onset and Death  Premature Birth 22 wks.  Due to (or as a conscouence of):  Non-Viable Fetus  Due to (or as a conscouence of):  Due to (or as a conscouence of):  Due to (or as a conscouence of):													
MOLIBON	IMMEDIATE CAUSE (FI disease or condition resulting in death)  Sequentielly list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injections)	Itions, ediete	Pr DUE TO	emature (OR AS A CONSE ON-Viabl	Birt OUENCE O	h 22 ၅։ tus ၅։	r the mo	de of dy	ing, suc	h aa card	elec or resp	akoma	reat,	Approximate interval Between
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THI SICIAM. MEDICAL	IMMEDIATE CAUSE (FI disease or condition resulting in death)  Sequentielly list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust in initiated events resulting in death) LAS  PART II. Other algnific.  25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	itions, ediete YING lury ST and conditions	Pr DUE TO DUE TO	emature (OR AS A CONSE  (OR AS A CONSE  (OR AS A CONSE  (OR AS A CONSE  death but not	Birt COUENCE O  COUENCE O  COUENCE O  COUENCE O	h 22 f): tus f): f):  OTHE 4 □ Nu	26. PL	g cause of Draw ACE OF Draw 5 Revenue ACE OF Revenu	given in	Part i.	24a. WAS AN PERFOI	A AUTOPSY RMED?	24	Approximate interval Betwee Onset and Deat on Deat and Deat on Deat on Deat on Deat on Death of Death
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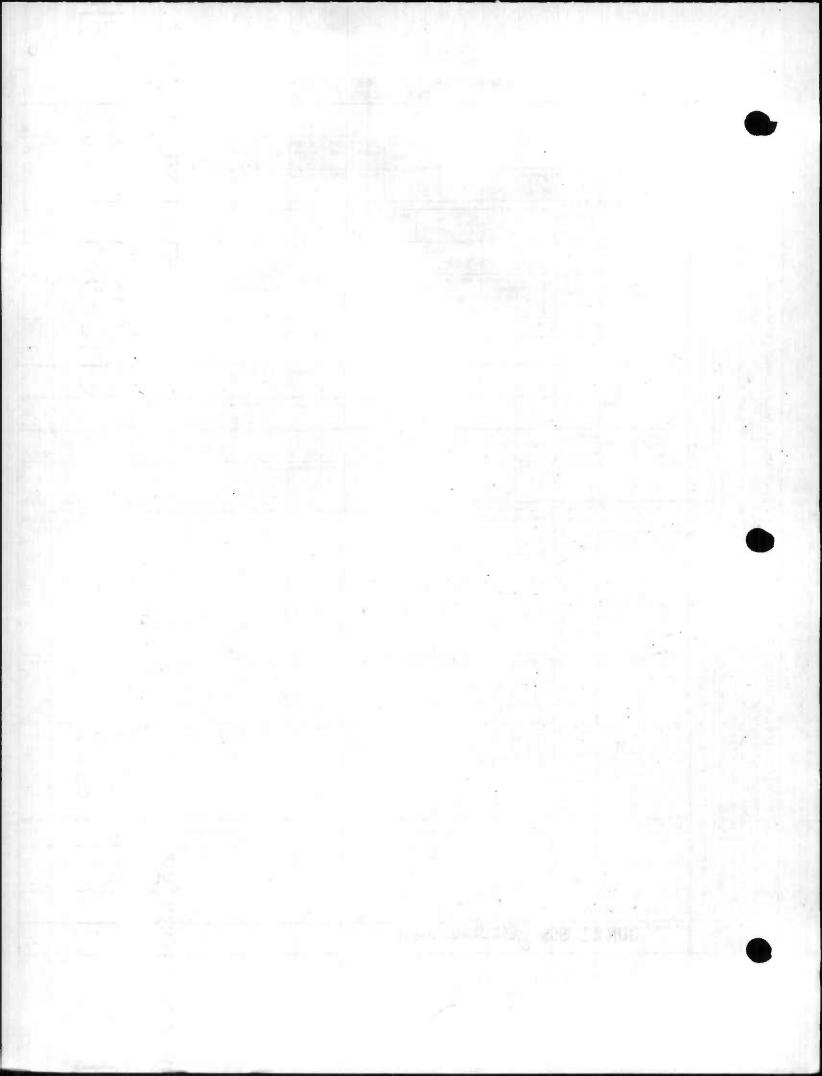
D20223

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Mangala Pandya, 7600 Carroll Ave., Takoma Park, Md

32 RECHSTRING'S SIGNATURE

20912



should

Pages 1, 2, 3

permit.

**burial-transit** ending physician.

as the

DIRECTOR

FUNERAL

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COMPLETED

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RAYMOND ALFRED JOHNSON 1995 JUN 1 6:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 042-14-1453 1 X M 2 | 1 77 YRS. Sept.13,1917 Connecticut 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Maryland Wheaton 1 YES 2 X NO 10a. STREET AND NUMBER 101. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 4045 Adams Drive U.S.A. 20902 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yea, specify Cuban, Maxican, Puarlo Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married Specify: White 3 Wildowed 4 Divorced <u>WWII,Korea,</u>Vietnam 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 1 Military Service U.S. Army 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Melanize Lord Carl Wilhelm Johnson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4045 Adams Drive, Wheaton, Md. 20902 Vivian E. Johnson 20a. METHOD OF DISPOSITION
1 X Burial 2 Crembion 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) 6/5 Flintstone, Maryland Rocky Gap Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Olin J. Molesworth, P.A., Funeral Home Williams 26401 Ridge Road, Damascus, Maryland 23. PART f. ther the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final Onaet and Death** disease or condition SEVERE MULTIVESSEL CORONARY ARTERY DISEASE reaulting in death) 5 years DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST

24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 XNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 2 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Ainpetient 2 ER/Outpetient 3 DOA **EXAMINER?** OTHER: 1 YES 2 NO Home 5 ☐ Rasidence 8 ☐ Other (Specify) 27. MANNER DE DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide

29e. CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. (Check only one)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

2 \_\_ MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) elloge MD-047454-L (PA) JUNE 2, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN H. KELLOGG, LCDR, MC, USNR

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

32. REDISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) **JUN 05** 

BALTIMORE, MARYLAND 21215-0020

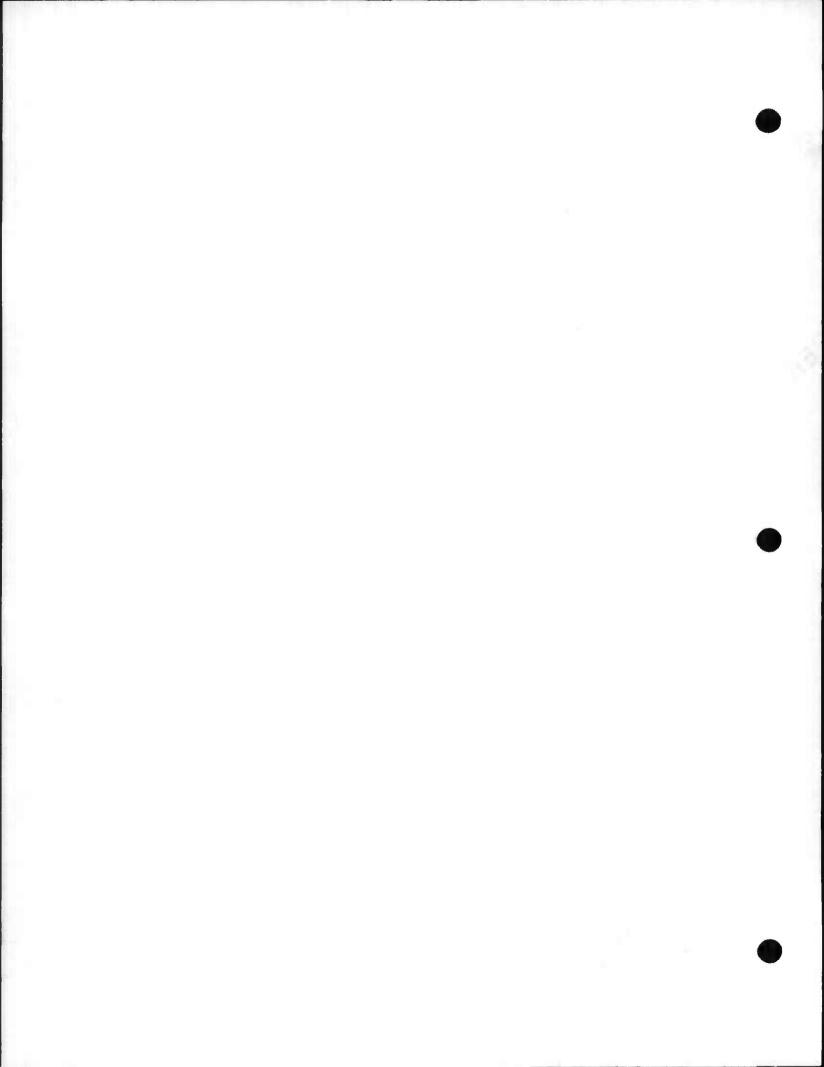
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF				3. TIME OF DEATH
	ALFRE		JONES	3				MAY :	DA	995	YEAR	1:20A M		
,	4. SOCIAL SECURITY NUME 222-44-25	15	5. SEX	e. AGE (In yrs. la	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF			Countr	IPLACE (State or Foreign
	9a. FACILITY NAME (If not in	stitution, give a	treet and number)			9b. CITY	16. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF						_	
DIRECTOR	THE J		OPKINS H	OSPITAL		BALTIMORE CITY								,
<u> </u>	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY
L DIR	Delaware  10. STREET AND NUMBER	Suss	ex ————		Ge	Georgetown							10d. INSIDE CITY LIMITS?  1X YES 2 NO	
FUNERAL	7th Booke	19947						10g. CITIZEN OF WHAT United S						
BY	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S. AF	MED NO		II yes, sp	ENDENT Cocify Cuba	n, Maxicar	IIC ORIGIN? (S n, Puerto Rica :	pecify Yea n, afc.)	or No—	Black	E — American Indian, k, White, atc. ////////////////////////////////////
9	15. DEC	EDENT'S EDUC	CATION	16a. Di	CEDENT'S	USUAL O	CCUPATIO	ON .		16b. Kil	D OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0 12th		College (1-4 or 5	life	nema	se retired.)	ourng mo	ST OF WORKE	ng	Но	me			
	17. FATHER'S NAME (First, M. Alford Le	ee Car	non					18. Mori Ber	nice	ME (First, Midd e Pal	le, Maiden S Mer	Sumame) Can	non	
TO BE	19a. INFORMANT'S NAME (7) Alford Ca			19	b. MAILING	ROOI	S (Street a	nd Number	or Rural R	orget	City or Town	, State, Zip	Code)	947
	20a METHOD OF DISPOSITI	ION on 3 - Remo	oval from State	20b. PLACE	AND DATE	OF DISPOS	SITION (Na	ma of		DATE	20c. LOC	CATION —	City or To	nwn, State
	4 Donation 5 Other 21. SIGNATURE OF FUNERAL	(Specify)		Mt.	Calv	ery	Cer				Cor	cor	d,D	Е.
:	LI DO A O A	L SERVICE LIC	ENSEE		1		Your	ng 's	Fu	neral nt St	Hon	nes	199	73 F
	23. PART I. Enter the di	seases, or c	omplications the	t caused the de	ath Oo						•		•	
	shock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart fellure.    ai	List only one eat	ise on each line					ing, saci	T als Cordina	ОГТОВРИ	atory an	,	Approximate Interval Between Onset and Dasth
CERTIFICATION	disease or condition resulting in death)  a. Congestive Neart failure  (DUE TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):													
CERT	resulting in deeth) LAS		U											
MEDICAL	PART ii. Other significe	nt condition	s contributing to	deeth but not i	esulting	in the un	deriying	) cause ç	lven in i		PERFORM	WED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TORACCO III	SE CONITI	URLITE TO CA	LIST OF DEA	TIL VE		10 17				,			1 - YES 2 NO
AN	DID TOBACCO U		IBUIE IU CA		E OF DEAT			UNC	ERIAIN	<u> </u>				
Sic	EXAMINER?		HOSPITAL:			OTHER	R:	- 04						
PHYSICIAN:	27. MANNER OF DEATH		28s. DATE OF (Month, D	INJURY	26b. TIM		28c. INJ	JRY AT	aldence (	28d. DESCRI		JURY OC	CURED	
B√	2 Accident	Pending Investigation Could not be	28s. PLACE O	F INJURY — At ho		М	1 🗌 Y	ES 2 [	NO NO	26f. LOCATIO	N (Street ar	nd Number	or Rural R	Inute Number
13.1	4 Homicide	determined	building.	arc. (Specify)						City or To	wn, State)			
COMPLETED	(Check only one)  1 CERTIFIER  1 CERTIFIER  2 MEDI	CAL EXAMINE	CIAN: To the best of R: On the bests of a:	my knowledge, de camination and/or	ath occum	nd at the ti	ime, date pinion, de	and place, eath occur	and due t	to the cause(a	) and menr place, and	ner as stat	ed. e cause(s)	) end menner as stated.
TO BE	296. SIGNATURE AND TITLE	ell ;	Fort,	MD					9178			29d. DAT	E SIGNED May	(Month, Day, Year) 24, 1995
	Mary Nel	1 10	rel, mo	SE OF DEATH (ITE	600 (Type	Print) No	rth	Walk	SA	rct	Balt	more		21, 1995
	31. DATE FILED (Month, Day, 1)	<b>6</b> 1995	32. MEGISTRA	AURILIAN KA	dall									



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hed by the hospital or attending physician.	re attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.		and 20 name
o may be retained by tr	page 5 st		inar must be notif
n. rage o n	eral director.		niner mus
e executed within 24 hours after death. Pag	by the fund	emoval.	dical exan
IN 24 HOUR	ely filled in	nation, or r	the me
ecuted with	nd complet	burial, cren	affe event
IICAIE DE EX	physician a	ne prior to	her fraum
neam ceru	e attending	Nental Hygie	ury or off
res mar me	igned by th	ealth and M	any ini
inhau wei al	has been s	Dept. of H	n 23 show
SILIAN: IR	certificate	h the State	d or Hen
NUMB PH	R. After this	ir death wit	is marke.
L UR ALLE	L DIRECTOR	hours afte	Hem 28
HE MUSPILIA	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete	led within 72	IMPORTANT if hem 28 is marked, or item 23 shows any injury or other traumatic event, the medical examination
2	2	De fi	IMP

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR DAY MAY 24 MILDRED ELIZABETH JONES A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign JUNE 25 1918 1 M 2 TYF YRS. 222-01-8480 76 MARYLAND 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY DE SUSSEX SELBYVILLE YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? BOX 343, WILLIAMS STREET 19975 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: Spec//y WHITE BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

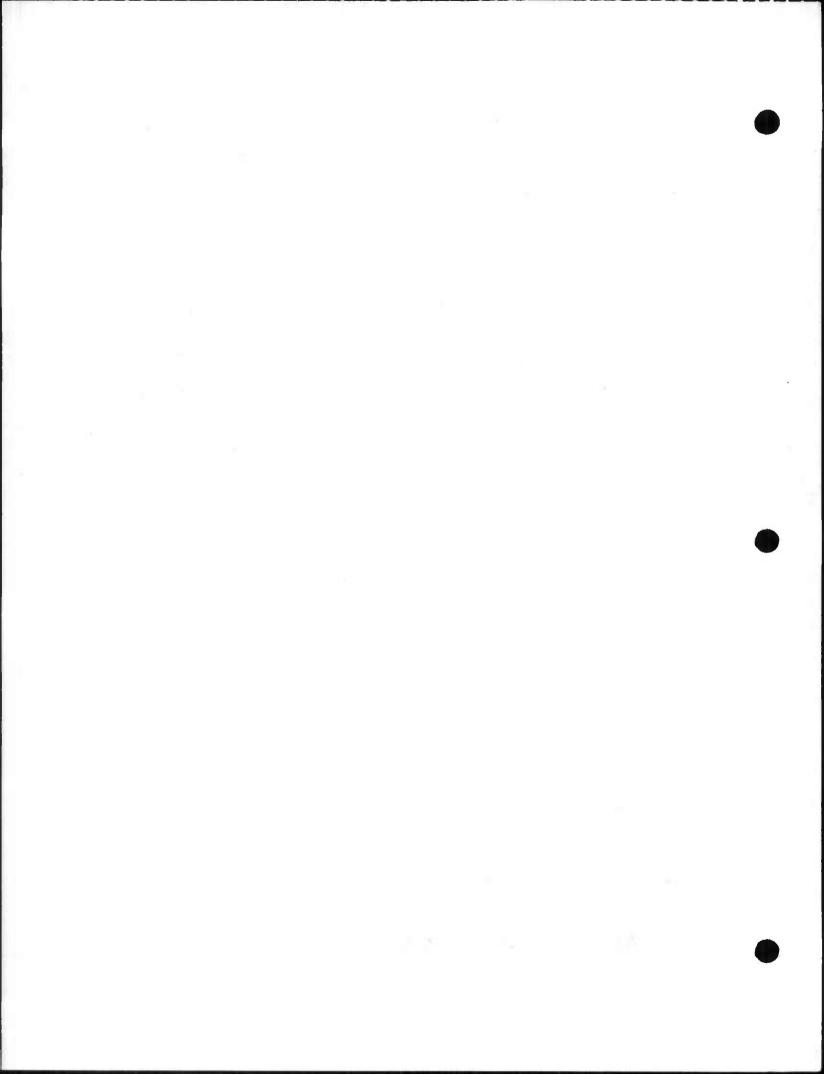
"Out blind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 11 CLERK **GROCERY** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maider Surname LEVI J. FREEMAN ELIZABETH K. LEWIS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES HALL BOX 343, WILLIAMS STREET, SELBYVILLE, DE 19975 20s. METHOD OF DISPOSITION
1 Spuriel 2 Cremetion 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE REDMEN'S CEMETERY 5/27/95 SELBYVILLE, DELAWARE H. BIGNATURE OF FUNDIRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HASTINGS FUNERAL HOME, SELBYVILLE, 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heert feilure. List only one cause on each line. interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition\_\_\_ CITTHYOSIS resulting in death) patitis CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in daeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, OSPITAL: X Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation Accident 28e. PLACE OF INJURY — Al home, farm, streel, factory, office building, stc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 X CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(e) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 9 LETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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3 0 1995

Julia Davidson Rardall



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4. 80
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FOR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR		CERTIF	ICATE O	PUEATH	R	EG. NO.		
- 63	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATN DAY		3. TIME OF DEATH
	Aĭ	UDREY MAI	E JOHN:	S		MAY	29,	1995	12:35 P.M
	Committee of the Commit		(In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF B (Month, De)	ATH	8. BIRTI Count	NPLACE (State or Foreign
		M 2 XF 5	7 YRS.	MONTHS DATE	HOURS MIN.	JAN 20			RYLAND
~	9n. FACILITY NAME (If not institution, give street a				N OR LOCATION OF D	DEATN	9	c. COUNTY OF D	DEATN
5	PRESIDENTIAL WOODS N	NURSING CE	NTER	ADELP	HI		E	PRINCE	GEORGES
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOC	CATION				10d, INSIDE CITY
H	MARYLAND PRINCE (	GEORGES	FT	. WASHI	NGTON				LIMITS?
	10e. STREET AND NUMBER				101. ZIP CODE		1 10	Da. CITIZEN OF 1	WHAT COUNTRY?
FUNERAL	7604 JAYWICK AVENUE				20744			JNITED	
S		WAS DECEDENT EVER IN	N U.S. ARMED	13. WAS D	ECENDENT OF NISPA	NIC ORIGIN? (Sp	ecity Yes or	No- 14. RAC	E — American Indian,
ВУ Б		FORCES? 1 YES		If yes,	specify Cuben, Mexic ES 2 NO Speci		etc.)		ck, White, etc.
								BLA	.CK
I	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	NN >leted)	16a. DECEDENT'S (Give kind of a life. Do NOT us	work done during i	TION most of working	16b. KINI	OF BUSINE	SS/INDUSTRY	
7	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	CLERK	,		EED.	TDAT (	00110000	Thim
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		OBLICK	111 151	10 MOTHER'S N	AME (First, Middle		GOVERNM	ENT
	EDDIE COLLINS				ANNIE	FAULKN		name)	
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stree	it and Number or Rural			tate 7in Codel	-
6	DENTON JOHNS (HI	USBAND)			AVENUE, F				207//
	204_METHOD OF DISPOSITION	20b	PLACE AND DATE	OF DISPOSITION (		DATE		ION — City or To	
	1 XBurlet 2 Cremation 3 Removal t 4 Donation 5 Other (Specify)	rom State cem	D ST VET	ERANS C	EMETERY	6/2	CHELT	ГЕМНАМ	MARYLAND
	21. SIONATURE OF FUNERAL SERVICE LICENSE	5 0			AND ADDRESS OF FA	ACILITY			
	1/by 1 F	MI D	M85	9   ALE	XANDER S.	POPE 1	FUNERA	AL HOME	S
	23. PART i. Enter the diseases, or comp	cetions that caused	the deeth. Do r	ot enter the n	node of dying, au	ch as cardiac	or respiret	ory arrest.	E_MD_20747
	ahock, or heart failure. List	only one cause on e	ach iine.						Interval Between Onset and Death
- 1	disease or condition resulting in death)	INTRACERI	FRDAT UI	EMODDIIA	O.F.				1 Year
- 1	a	DUE TO (OR AS A	CONSEQUENCE OF	P):	35.				1 leat
Z	Sequentially list conditions, b								
Ĕ	if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	r):					
0	CAUSE (Disease or Injury		CONSTRUCTOR						
TT I			CONSEQUENCE OF	·):					
RTIFI	that initiated events reaulting in death) LAST	DUE TO (OR AS A							
CERTIFI	reaulting in death) LAST								
AL CERTIFICATION	PART II. Other algnificant conditions con	ntributing to death b	ut not reaulting i	in the underlyi	ing cause given in	Part I. 24a.	WAS AN AUT		WERE AUTOPSY FINDINGS
DICAL	reaulting in death) LAST	ntributing to death b	ut not reaulting	in the underlyi	ing cause given in	- 1	WAS AN AUT PERFORMED YES 2 X	D?	AMILABLE PRIOR TO COMPLETION DF CAUSE
DICAL	PART II. Other algnificant conditions con SEPSIS, RENAL	ntributing to death b				10	PERFORME	D?	AMAILABLE PRIOR TO
DICAL	PART II. Other algorificant conditions consistency.  SEPSIS, RENAL  DID TOBACCO USE CONTRIBU	FAILURE	F DEATH YE	S 🗆 NO I	UNCERTA	10	PERFORME	D?	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?
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DICAL	PART II. Other algnificant conditions consistency.  SEPSIS, RENAL  DID TOBACCO USE CONTRIBUTION OF THE PROPERTY OF THE PROPERT	FAILURE  JTE TO CAUSE O  SPITAL: Inputtent 2 □ ER/Outp	F DEATH YE	S NO NO NOTHER:	UNCERTAIN UNCERT	N	PERFORMEI YES 2 (X)	D7 NO	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?
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BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors of the service of the	TE TO CAUSE O	PEATH YE 28. PLACE OF DEAT  actions 3 DOA  286. TIM INJ  — At home, term, 6	S NO THER: 4 Nursing Ho URY M 1	UNCERTAL  Dome 5 Gesidence  NJURY AT  VORK?  YES 2 NO	8 Other (Spe 28d, DESCRIB	PERFORMET  YES 2 (A)  city)  E NOW INJU	D7 NO	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors SEPSIS, RENAL  DID TOBACCO USE CONTRIBUES. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 10  27. MANNER OF DEATN  1 Netural 5 Pending Investigation  3 Suicide 8 Could not be determined	TE TO CAUSE O  SPITAL: Inpatient 2 SPIVOUP  280. DATE OF INJURY (Month, Day, Year)  280. PLACE OF INJURY building, atc. (Spec	PDEATH YE 26. PLACE OF DEAT  actions 3 DOA  28b. TIM INJ  — At home, term, a	S NO NO NO NO NO NO NO NO NO NO NO NO NO	UNCERTALI e) ome 5 Residence NJURY AT WORK? YES 2 NO	8 Other (Spe 28d, DESCRIB 281, LOCATION City or You	YES 2 (A)	RY OCCURED	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors of the part of the pa	FAILURE  JTE TO CAUSE O  SPITAL: Inpatient 2 = ER/Outp  28e. DATE OF INJURY (Month, Day, Vear)  28e. PLACE OF INJURY building, stc. (Spec	PEATH YE 28. PLACE OF DEAT  and the state of	S NO THER: 4 A Norsing Ho E OF UNY M 1 Street, factory, off	UNCERTALION UNCERE	8 Other (Spe 28d. DESCRIB 281. LOCATION City or Tom	YES 2 A	D?  NO  RY OCCURED  Number or Rural R  as stated.	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO
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BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors of the part of the pa	FAILURE  JTE TO CAUSE O  SPITAL: Inpatient 2 = ER/Outp  28e. DATE OF INJURY (Month, Day, Vear)  28e. PLACE OF INJURY building, stc. (Spec	PEATH YE 28. PLACE OF DEAT  and the state of	S NO THER: 4 A Norsing Ho E OF UNY M 1 Street, factory, off	UNCERTALION OF THE PROPERTY OF	8 Other (Spe 28d, DESCRIB) 281. LOCATION City or You be to the cause(e) a time, date end p	PERFORMEL YES 2 A  city) E NOW INJUI (Street and in, State) and menner	D?  NUMber or Rural R  as stated.  se to the cause(s)  d. DATE SIGNED	ARALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  a) end manner ee stated.  0 (Month, Day, Year)
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors SEPSIS, RENAL  DID TOBACCO USE CONTRIBUES. RENAL  DID TOBACCO USE CONTRIBUES. RENAL  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO   1   1   1   1   1   1   1   1   1	TE TO CAUSE O  SPITAL: Inpatient 2 = ER/Outp  28e. DATE OF INJURY (Month, Dey, Veer)  28e. PLACE OF INJURY building, atc. (Spec	PEATH YE 26. PLACE OF DEAT  antient 3 DOA  286. TIM INJ  — At home, term, a  ledge, death occurre a end/or investigation	S NO NO NO NO NO NO NO NO NO NO NO NO NO	UNCERTALION  UNCER	8 Other (Spe 28d, DESCRIB) 281. LOCATION City or You be to the cause(e) a time, date end p	PERFORMEL YES 2 A  city) E NOW INJUI (Street and in, State) and menner	D?  NO  RY OCCURED  Number or Rural R  as stated.  se to the cause(s	ARALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  a) end manner ee stated.  0 (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors SEPSIS, RENAL  DID TOBACCO USE CONTRIBUES. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1  27. MANNER OF DEATN  1 Natural 5 Pending Investigation Investigation Could not be determined  2 Accident Could not be determined  29. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: One DEATH One DEATH One DEATH One DEATH One DEATH ONE	FAILURE  JTE TO CAUSE O  SPITAL: Inpatient 2 = EN/Outp 28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, stc. (Spec	F DEATH YE 26. PLACE OF DEAT Detient 3 DOA 286. TIM INJ — At home, term, a ledge, death occurre n end/or investigation ATH (ITEM 27) (Type,	S NO   NO   THE (Check only one OTHER: 4 & Nurshing Ho E OF URY M 1   Street, factory, off at the time, darm, in my opinion, Print)	UNCERTALION OF THE PROPERTY OF	8 Other (Spe 28d. DESCRIB 281. LOCATION City or Tow e to the cause(e) a time, date end p	PERFORMEL YES 2 A  city) E NOW INJUI (Street end I n, State) end menner	RY OCCURED  Number or Rural R  as stated.  Je to the cause(s)  May 29	ARALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  a) end manner ee stated.  0 (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificant conditions colors.  SEPSIS, RENAL  DID TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER?  1 YES 2 NO 10  27. MANNER OF DEATN 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 1 Check only 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One) 2 MEDICAL EXAMINER: One of the control of	FAILURE  JTE TO CAUSE O  SPITAL: Inpatient 2 = EN/Outp 28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, stc. (Spec	PEATH YE 28. PLACE OF DEAT  28b. TIM  28b. TIM  At home, 1erm, 6  ledge, death occurre n end/or investigation  ATH (ITEM 27) (Type,	S NO   NO   THE (Check only one OTHER: 4 & Nurshing Ho E OF URY M 1   Street, factory, off at the time, darm, in my opinion, Print)	UNCERTALION OF THE PROPERTY OF	8 Other (Spe 28d. DESCRIB 281. LOCATION City or Tow e to the cause(e) a time, date end p	PERFORMEL YES 2 A  city) E NOW INJUI (Street end I n, State)	RY OCCURED  Number or Rural R  as stated.  Je to the cause(s)  May 29	ARALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number,  a) end manner ee stated.  0 (Month, Day, Year)

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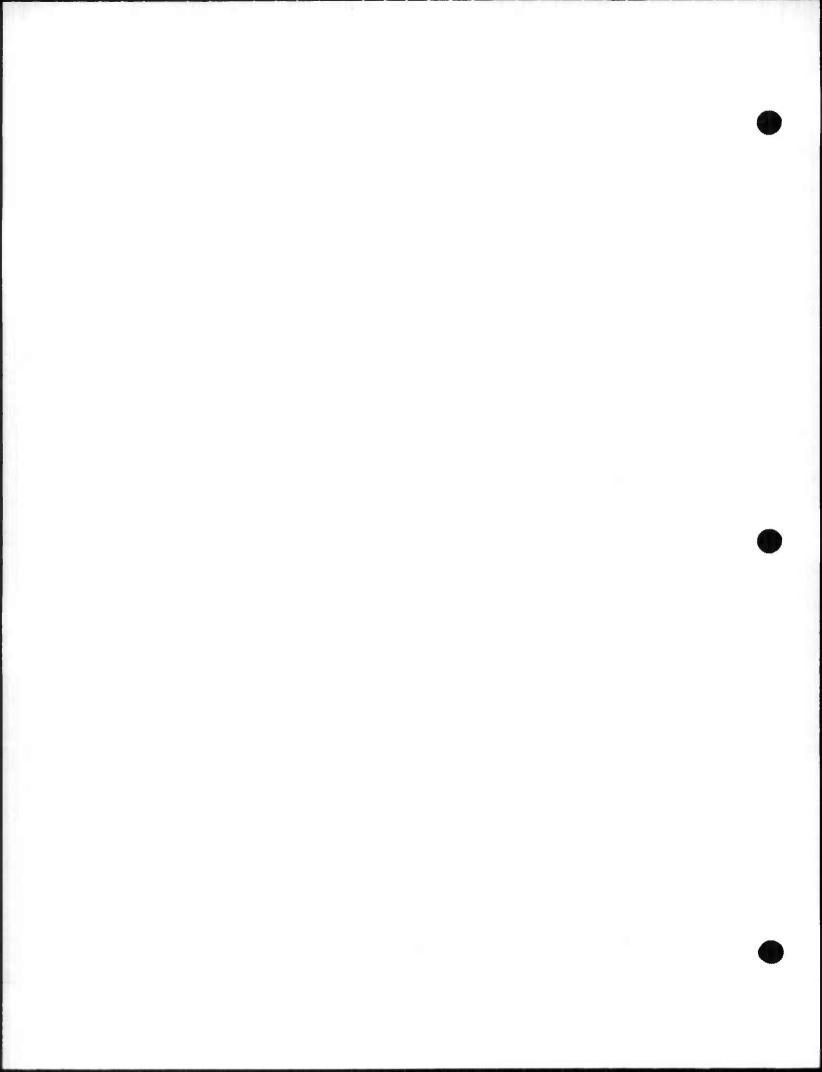
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. A hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

INPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

DHMH-18 Rev 1/89

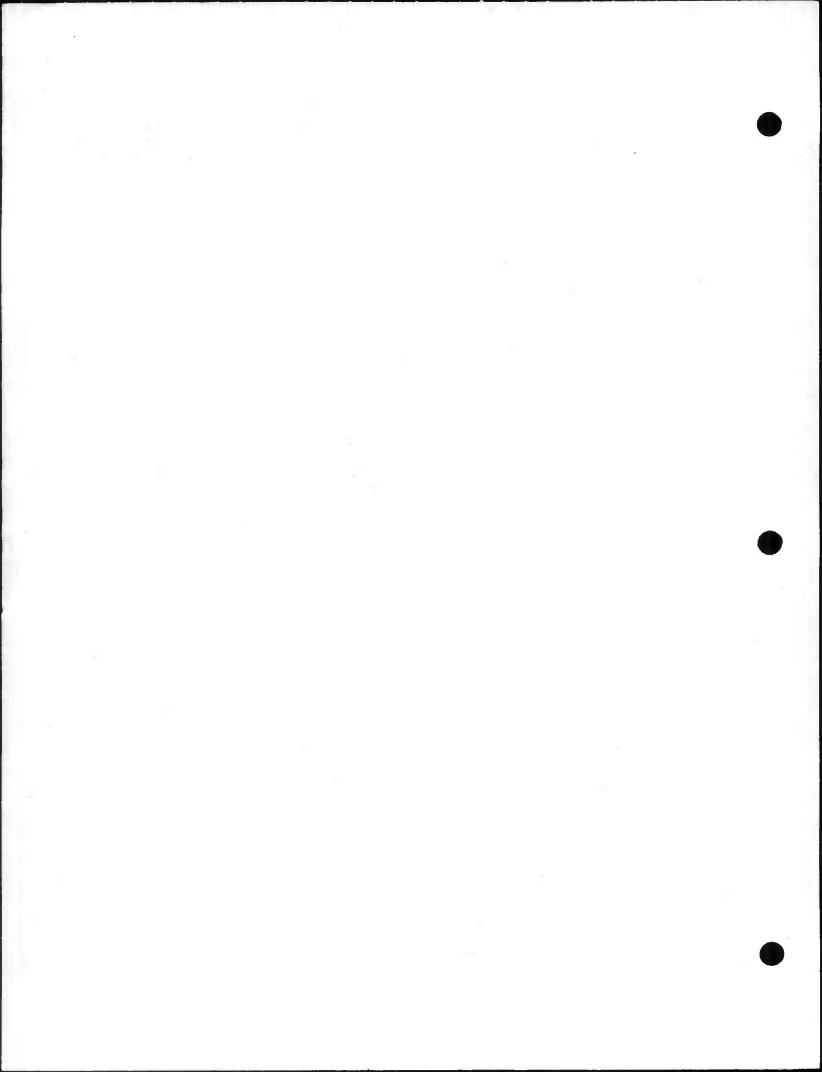


fter death. Page 6 may be retained by the hosp	the funeral director, page 5 should be detached	oval.	ai examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITA	TO THE FUNERAL	be filed within 72	IMPORTANT: II	

ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF M		DEPAR					MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Li	nst)				- 0.	DEA		2. DATE OF DEATH	0.		3. TIME OF DEATH		
	Bayard T. Ke:	ller							May 28,	1995	YEAR	6:50 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF BIRTH		B. BIRTI	HPLACE (State or Foreign		
	214-30-7514	1 № M 2 🗆 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb. 16,	1923	Mar	yland		
_	9a. FACILITY NAME (If not institution, g				9b. CITY	TOWN	R LOCATI	ON OF D	EATH	9c. COL	INTY OF C	DEATH		
6	17204 Friends H				San	dy S	prin	g	Montgomery					
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COL			10c. CIT	Y. TOWN C	R LOCAT	ION					10d. INSIDE CITY		
DIRECTOR	Maryland Mo	ntgomery			dy S							LIMITS?		
										10g. CITIZEN OF WHAT				
ER	1720/ F-1 1 H									USA				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT							NIC ORIGIN? (Specify		14. RAC	E — American Indian,		
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, OIVE W	X YES 2 1	NO			2 NO		m, Puerto Rican, etc.)		Spec	k, White, atc.		
		_ WW	II									White		
COMPLETED	15. DECEDENT'S I (Specify only highest g		(G	ECEDENT'S	work done i	during mo	N st of working	ng	16b. KIND OF E	USINESS/IN	DUSTRY			
ן ב	Elementary/Secondary (0-12)	College (1-4 or 5 +)		Do NOT u	,				,, a, p		C D	C		
<u> </u>	17. FATHER'S NAME (First, Middle, Last)			Anal	yst				U.S. D	-	or D	efense		
	Dr. Bayard This								ME (First, Middle, Maid	en Surname)				
W	19a. INFORMANT'S NAME (Type/Print)	TE RETTEL	19	b. MAILING	ADDRESS	/Street e			Hughes Route Number, City or To	was State 7	in Codel			
일	Lt. Col. Bayard	T. Keller,							estminster			nd 21157		
	20a. METHOD OF DISPOSITION		20b. PLACE	_						OCATION -	_			
- 1	1 K Burlel 2 Cremation 3 F 4 Donation 8 Other (Specify)	iemoval from State	Gran						1			Maryland		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	1/	. 1	24.	NAME AN	D ADDRE	SS OF FA	cutyHines-I	Rinalo	li Fu	meral Home		
	havis	mater	4/1/1	lan	$\mathcal{N}^1$	1800	) New	7 Har	npshire Av	renue				
	23 PART I. Enter the diseases,	or complications that	caused the de	CLA AC	N anias	TTV6	t of	T TII	g, Marylar	1d Z(	1904			
- 1	snock, or neart failu	re. List only one ceus	e on each line	).	iot einer	trie mo	ae or ay	irg, auc	n se cerdiec or res	piratory ar	reat,	Approximata Interval Between		
	iMMEDIATE CAUSE (Final disease or condition	END-	s And	2 0	10 -	un '	SDAL		DICOLAR	0		Onset and Death		
	reaulting in death)		OR AS A CONSE			. , , ,	7010	2	DISTORI			6 years		
z					,									
2	Sequentially list conditions, if any, leading to immediate	DUE TO (	OR AS A CONSE	QUENCE O	F):									
5	cause. Enter UNDERLYING CAUSE (Disease or injury	c												
EKIIFICATION	that initiated events resulting in death) LAST	DUE TO (	OR AS A CONSE	OUENCE O	F):									
E L		_ d												
اي	PART ii. Other algnificent condit	tions contributing to d	deeth but not r	resuiting	in the un	deriying	cause ç	iven in	Part i. 24a. WAS A	N AUTOPSY	24b	. WERE AUTOPSY FINDINGS		
3		I/A							PERF	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC										2 94 110		OF DEATN?  1 YES 2 NO		
	DID TOBACCO USE CON	VTRIBUTE TO CAL	JSE OF DEA	TH YE	1 🗆 2	10 🛭	UNC	ERTAIL	v			NIA		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEA	TH (Check o	only one)								
2	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		8 X Ra	sidenca	8 Other (Specify)					
PHTSICIAN:	27. MANNER OF DEATH	28a. DATE OF II (Month, Day		28b, TIM	E OF URY	28c. INJI	JRY AT		26d. DESCRIBE HOW	INJURY OC	CURED			
- 1	1 Natural 5 Pending 2 Accident Investigation	on		-	_ M		ES 2 [	NO	_					
	3 Suicide 8 Could not	building, at	INJURY — At ho tc. (Specify)	me, ferm, s	street, facto	ory, office			28t. LOCATION (Stree City or Town, Stat	t and Numbe	r or Rurel I	Ploute Number,		
										_				
COMPLEIED		YSICIAN: To the beat of n												
5	2 MEDICAL EXAM	IINER: On the basis of axe	imination end/or i	Investigatio	n, in my o	pinion, de	ath occur	ed at the	time, data and place,	and dua to ti	ha cause(s	a) and manner as stated.		
	296. SIGNATURE AND TITLE OF CERTIF		1				29c. LICE			29d. DAT	E SIGNED	(Month, Day, Year)		
	Ames a. Mr	voi, Mis	*				0	242	543	•	5-	28-95		
-	JAMES A. RUSSI,	WHO COMPLETED CAUSE	S N. L	M 27) (Type, Le 1 S U	Print) Re U	JORI	-D 1	3 LM	O., SILVER	SPR	ina,	MD 20901		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE											
	MAY 30 199	95 Juli As	witeroffe	1 11										
		//		VIII-										





ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF N	MARYLAND / CE				EALTH DEAT		MENTA	L HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH		T	3. TIME OF DEATH
	KRISTOPHER K	LE K	ING						MAY	7 25	, 19	95	9:06 A M
		5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER		IF UNDER	24 HRS.		OF BIRTH		BIRTHE	PLACE (State or Foreign
	220-82-5476	1 💢 M 2 🗌 F	23	YRS.	MONTHS	DAYS	HOURS	MIN.	FE	h, Day, Year)	972	Country	MARYLAND
	9a. FACILITY NAME (If not institution, give etre	et end number)			9b. CITY	, TOWN O	R LOCATIO	N OF DE			9c. COUNT		
OR	WASHINGTON ADVE	NTIST H	HOSPITA	L	TAR	OMA	PAR	RK			MON	TGO	MERY
DIRECTOR	RESIDENCE OF DECEDENT  100. STATE  100. COUNTY			10n CIT	Y, TOWN (	OR LOCAT	1011					1	
E		OMERY		IOC. GIT								- 1	10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	TOPHSIV1			1	ERWC	ZIP CODE		-		40. 017170		1 TYES 2 NO
R	6700 MUNCASTE	R MILL	מפ					0855					HAT COUNTRY?
FUNERAL				ED	13.	WAS DECI				N? (Specify Yes		U.S.	American Indian.
	764	FORCES? 1	T EVER IN U.S. ARM YES 2 NO			If yes, spe	cify Cuber	ı, Mexicer	, Puerto	Rican, etc.)	U. NO.	Black,	White, etc.
ВУ	3 Wildowed 4 Divorced						2 QLINO	эрвспу				Specify	WHITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	TION ompleted)			USUAL O		N st of working	7	16b	. KIND OF BUS	INESS/INDUS	TRY	
Ē	Elementary/Secondary (0-12)	College (1-4 or 5	Man I	Do NOT u	se retired.)		it or working						
N P	12			INS	TRUC	TOR					OW BO	ARD]	ING
	17. FATHER'S NAME (First, Middle, Last)	TETRIC	-				18. MOTH	ER'S NAM	AE (First, I	Middle, Malden S	,		
8		KING							ARGA		· Mc		ISH
5	190. INFORMANT'S NAME (Type/Print)  GATL W. ZIMT	NSKY	1							ber, City or Town			
Ì	20a. METHOD OF DISPOSITION	NSKI		7002				0.9		ERSON,			
	1 Buriel 2 Cremation 3 Remov	al from State	20b. PLACE AP cometery, come CHAM	ND DATE	ther place	NEA TOO	ne of		5/27		ATION — CI	-	
	21. SIGNATURE OF FUNERAL SERVICE LIGHT	RISEE .	CHAM	DETUO			O ADDRES			R	IVERD.	ر تلىلىA	MD.
	MALALA		.1										20910
_	11.11. AW	murus		0091		. W.	CHAI	MBER	S CO	. INC.	,SILV	ER S	PRING, MD.
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	mplications that st only one ceu	t caused the dee se on each line.	th. Do r	not anter	the mod	de of dylr	ng, such	as cere	diac or respir	atory arres	it,	Approximata interval Between
	IMMEDIATE CAUSE (Final disesse or condition	NADCOTA	0 1010010	TT 0 11									Onset and Death
	resulting in death) a.		C INTOXICA										
		DUE TO	(OR AS A CONSEOU	SEQUENCE OF):									
CERTIFICATION	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):												
PAT	if any, leading to immediate cause. Enter UNDERLYING				•								İ
Ĕ	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSEOL	JENCE OI	F):								
EH	resulting in death) LAST												
	PART II. Other algnificant conditions	contributing to	death but not re-	aultina	in the un	darlular	onune el	luna in F	Don't I	24s. WAS AN /		I	
CAL				outing .	(110 011	derrynig	cause g		art I.	PERFORI		1	WERE AUTOPSY FINDINGS NMILABLE PRIOR TO COMPLETION OF CAUSE
							_		-	1 YES 2	□ NO		OF DEATH?
Σ	DID TOBACCO USE CONTRI	DUITE TO CA	LICE OF DEAT	U VE	·	IO [	LINICI	EDTAIN		. /			YES 2 NO
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL	BUIE TO CA	26. PLACE				UNC	ERTAIN					
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER	₹:	- 03-0	227.79	1 35				
¥	27. MANNER OF DEATH	28e. DATE OF		28b. TIM		28c, INJU	5 Res		_	r (Specify) CRIBE HOW IN	HIBY OCCU	aen.	
	1 Natural S Pending	(Month, Da	ly, Year)	FOUN		WOF	RK7		UNKN		JOH! OCCU	NED	
BY	2 Accident Investigation 3 Suicide B Tit Could not be	28e. PLACE O	F INJURY — At hom					-	28f. LOC	ATION (Street or	od Number or	Arumi Bo	uta Number
回	4 Homicide 8 (Could not be determined	building,	atc. (Specify)		RESIDE			- 1	City	or Town, State of	700 NUI	COST	RO MILL RD.
COMPLET	29e. CERTIFIER	N: To the best of		_					DUNWO		ve e smek		
₹ I	(Check only one)  2 MEDICAL EXAMINER:												to select control of the
	29b. SIGNATURE AND TITLE OF CERTIFIER				.,, 0					war biace, end			
B	The A	11	Jil Til	0			O. C	. M .					Month, Day, Year) 26,1995
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIS	OF DEATH JITEM	27) /Tuna	Print1						FIF	2	.0,1090
	THE ODORE MIK				STR	EET	BA	LTI	MOR	E, MAI	RYI.AN	1D	21201
	31. DATE FILED (Month, Day, Year)		R'S SIGNATURE							_,	2111		
	MAY 30 1995			1.11									

5 A) - D 

3. TIME OF GEATH

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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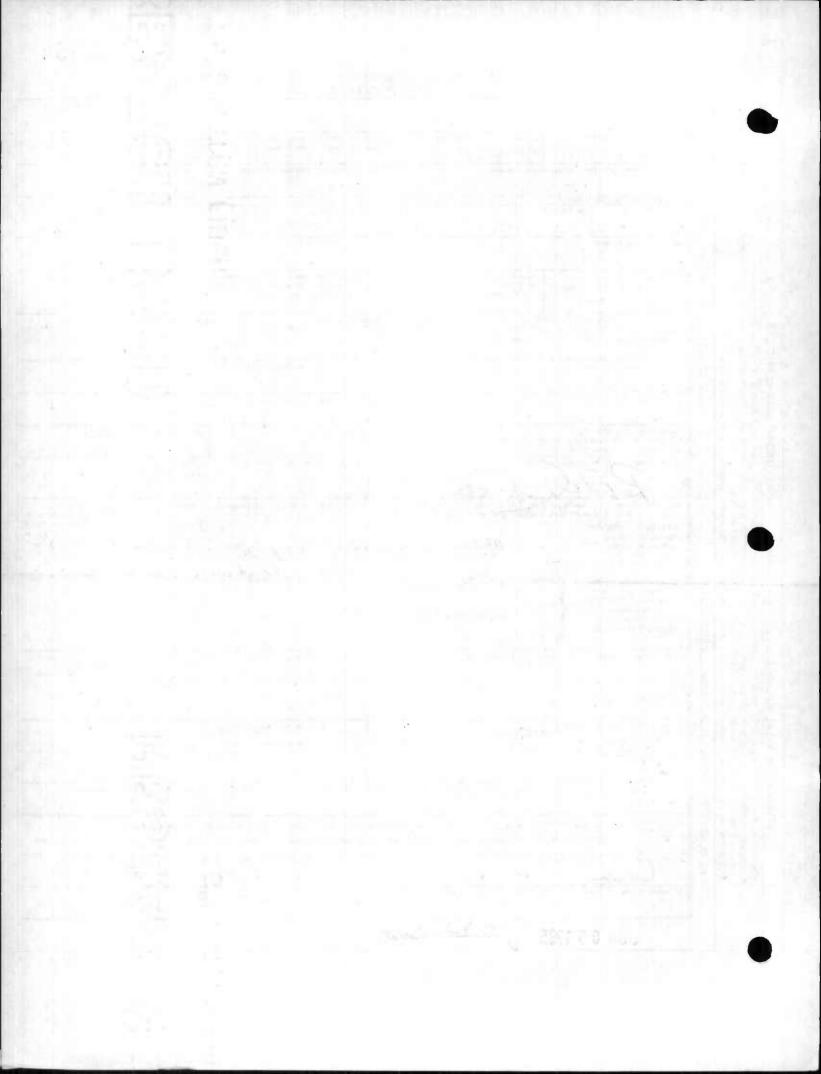
May oveno 4. SOCIAL SECURITY NUMBER 6. AGE (In 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 190-16-3074 1 M 2 X F 66 1928 Sept. 2, Pennsylvania 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Shady Grove Adventist Hospital Rockville, Montgomery 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg permit. 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 9515 Fern Hollow Way 20879 United States retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 K Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.) YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: White 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only hig ET College (1-4 or 5+) COMPL 12 National Retirement Corp. Accountant once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Meider Surname) Ħ Samuel C. Klink Bridget Anderson notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 2 Jacqueline Lilley 9515 Fern Hollow Way, Gaithersburg, MD 20879 within 24 nours after death. Page 6 may be Pe 20e. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Alverton Cemetery 4 Donation 8 Other (Specify) 5/29/95 Alverton, PA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 completely filled in by the rial, cremation, or removal. medicai 23. PART I. Enter or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart falls List only one cause on each line. Interval Between IMMEDIATE CAUSE (EInal Onset and Death disease or condition 事 Congestive resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF to burial, u pecuted Infancti traumatic CERTIFICATION the attending physician and Mental Hygiene prior to bur Sequentially list conditions, if any, leading to immediate prior cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART\_II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS Health and Insufficiency Dixbetes Melions AMILABLE PRIOR TO COMPLETION OF CAUSE amy 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL OTHER: 1 TYES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT After this ce leath with ti marked, 28d, DESCRIBE HOW INJURY OCCURED 1. Natural M 1 YES 2 NO ВҰ death ATTENDING Affer 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide ETED. 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 69 6 Could not be DIRECTOR after 28 4 Homicide determined hours 8 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. COMPL (Check only one) FUNERAL within 72 I 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. TO THE HOSPITION THE FUNERA
TO THE FUNERA
TO THE MACHININ 7 296. SIGNATURE AND PITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15 MEDICAL CENTER DR. #214, 12. RECIGITARIS SIGNATURE 01 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	HEGISTRAN			LITT	ICAIL	. Or	DEATH		REG. NO	).			
	1. DECEDENT'S NAME (First, Middle, Last)  CHARLES RAYMOND KI					I		_M	June 1, 1995			3. TIME OF DEATH 7:45 P M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthde											PLACE (State or Foreign	
	218-50-3002					THE DAYS HOURS MIN.		- (	Feb. 21, 1		Country		
	9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH			
OR	4601 Lynn Burke Road				Monrovia					Frederick			
5	RESIDENCE OF DECEDENT  10e, STATE  10b, COUN	TV		100 CIT	V TOWN O	BLOCA	TION					10d. INSIDE CITY	
DIRECTOR		derick	Monrovia								LIMITS?		
	10e. STREET AND NUMBER				1011 OV TA				10g. CITIZEN O			1 YES 2 NO	
RA	4601 Lynn Burke Road				21770				The East Land Street Section 2			J.S.A.	
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.				ARMED 13. WAS DECENDENT OF NISPANI							- American Indian,	
	1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE			2X NO If yes, specify Cuban, Maxican			axican, Pu	n, Puerto Rican, atc.)			, white, etc.  y: White		
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			Ba. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									
Ш	Elementary/Secondary (0-12)				(Give kind of work done during most of working life. Do NOT use retired.)								
COMPL	8 years			Carpenter					Carpentry				
00	17. FATHER'S NAME (First, Middle, Last)		18. MOTNER'S NAME (First, Middle, Maiden						Surname)				
BE	Clarence William	- 1		Virginia Lee Turner									
0	19a. INFORMANT'S NAME (Type/Print)							Number, City or To			I A VITTE		
	Mrs. Helen F. Ker	nnan		4601	Lynn	Bur	cke Roa	d Mor	rovia,	Mary.	land	21770	
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Re	movel from State	20b. PLACE	AND DATE	OF DISPOSI	TION /N	lame of		DATE 20c. L	OCATION —	-		
	4 Donation 5 Other (Specify)		Brown	nsvil			of Bret			ownsv	ille	, Maryland	
	22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, F										HOMES. P.A.		
ы	1201 NORTH MARKET ST. FREDERICK, MD 21701												
CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  B. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	C. DUE TO	DUE TO (OR AS A CONSEQUENCE OF):										
0	Page II Oh a law II a Maria a law II a												
EDICAL	PART II. Other significant conditions contributing to death out			not resulting in the underlying cause given in Par			n in Part	24a. WAS AN AUTOPSY PERFORMED?		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
ă										1 TYES 2 NO		COMPLETION OF CAUSE OF DEATH?	
Σ												1 YES 2 NO	
SICIAN:	OF MAR CARE DECEMBED TO MEDICAL	1											
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:												
PHYS	1 YES 2/K NO	28a. DATE O	ER/Outpetient	3 LI DOA		_	me 5 Raside			- IN ILIEN OO	OUDED.		
BY PI	1 Natural 5 Pending 2 Accident Investigation	Day, Year)	INJURY WORK?  M 1 YES 2 NO					86. DEȘCRIBE NOW INJURY OCCURED					
ETED	3 Suicide 8 Could not be detarmined 26e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify)								8f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLE	29a. CERTIFIER (Check only one)  1 CERTIFVING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  1 CERTIFVING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
BE	29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  0 - 18191  6 - 2 - 95												
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur G. Manalo MD 187 Thomas Johnson Drive Frederick, Maryland 21701												
	31. DATE FILED (Month, Day, Year)  32. RECOIFTRANCE, SIGNATURE  JULY D'ALLE D'A												
	JUN 0 5 199	15 Julia	thington!	Model	A				(5)				



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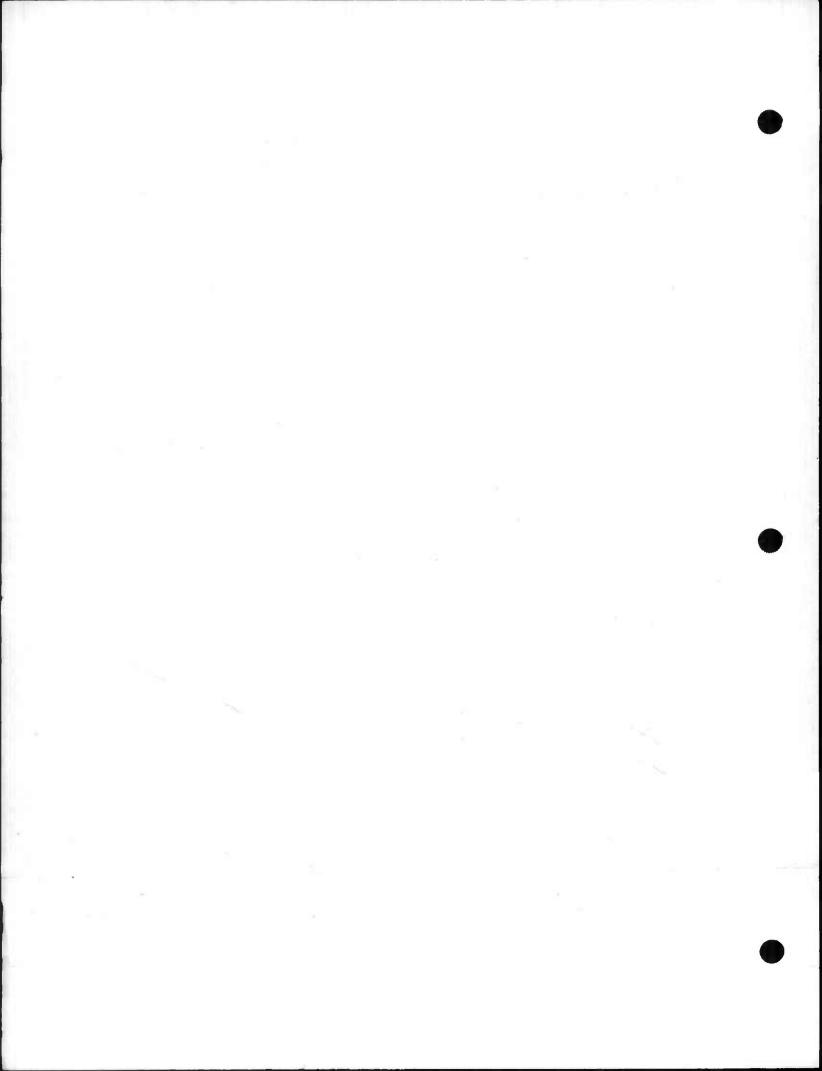
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN MONTH 3. TIME OF DEATN Dana Andrew KELLEY May 23 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (S (Month, Day, Year) DAYS HOURS 1 M 2 D F YRS. 579-76-8298 July 19, 1956 Wash. D.C. permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Doctors Community Hospital Lanham, MD Prince George's 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George's 1X YES 2 NO Mitchellville FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3407 Inverwood Lane use as the burial-transit 20716 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced Black. COMPLETED 16b. KIND OF BUSINESS/INDUSTRY Washington 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Spec be detached for Elementary/Secondary (0-12) Metropolitan Transit College (1-4 or 5+) Professional Bus Operator Authority (METRO) 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Vincent Kelley Jennie B. Miles BE funeral director, page 5 should notified t9e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Jennie Kelley 1907 Maryland Ave., NE., #6 Wash., DC 20020 20 9 20a, METHOD OF DISPOSITION 1 Å Burlel 2 ☐ Cremation 20c. LOCATION — City or Town, State
5 Bladensburg, MD 20b. PLACE AND DATE OF DISPOSITION (Name of after death. Page 6 may must cemetery, crematory or other pla Fort Lincoln 4 Donation 5 Other (S examiner 21. SIGNATURE OF FUNERAL SERVICE LICER 22. NAME AND ADDRESS OF FACILITY Tyrone J. Young Funeral Services n by the fremoval. 5635 Eads Street, NE, Wash., DC 20019 one that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, one cause on each line. medicai 23. PARTY Lenter the disc Approximate shock, or heart failu completely filled in interval Batween cremation, or IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition areles myo event, resulting in death) DUE TO (OR AS A CONSENUENCE OF) an and com traumatic NOI Sequentially list conditions. DUE TO (OR AS A CONSEDUENCE OF) if any, leading to immediate cause. Enter UNDERLYING attending physician CERTIFICAT Hygiene prior CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Mental signed by the a Health and Men PART II\_Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 14s. WAS AN AUTOPSY MEDICAL WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE DF DEATH? TIT YES 2 PANO shows a 1 YES 2 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 certificate has 25. WAS CASE BEFERRED TO MEDICAL 28-FLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 R/Outpatie 4 - Nursing Nome 5 - Residence 6 - Other (Specify) the 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED With marked this 1 Natural 5 Pending 1 YES 2 NO BY death 2 Accident Investigation DIRECTOR: At hours after de item 28 is r 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be ED 4 Nomicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTED FINE WITHIN 72 hours at IMPORTANT: If Item 2 COMPLET 29e. CERTIFIER 1 CEBMFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(e) and manner as stated. URE AND TITLE OF BE

dilwalar Randall

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

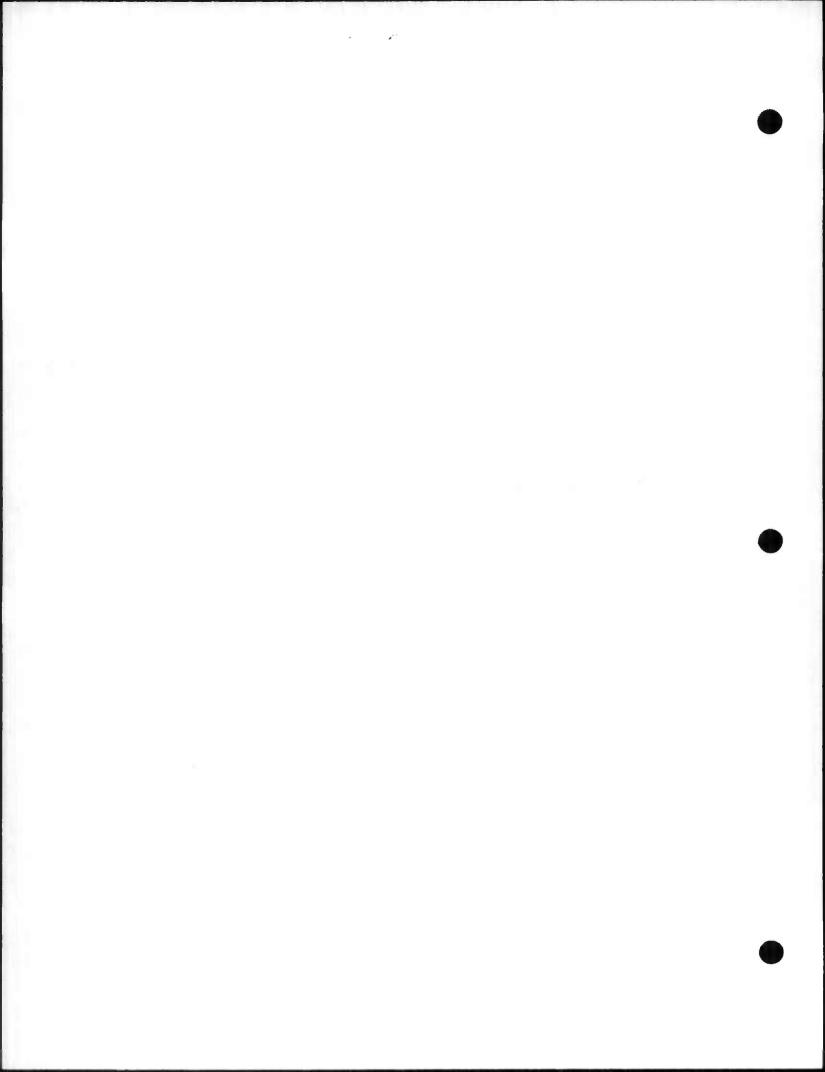
ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	JOS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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1 1	1. DECEDENT'S NAME (First, Middle, Last)  DELMAS  C.	KELLER				2. DATE OF OEATH MONTH	AY YE	
	4. SOCIAL SECURITY NUMBER						3, 199	
	225-01-4711		In yrs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0	MRTHPLACE (State or Forei country)
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DIRECTOR		nce George <sup>t</sup> s		TY, TOWN OR LOC				10d. INSIDE CITY LIMITS?
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FUNERAL	6100 Westchester	r Park Drive	#I5			0740	U.S.	
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BY F	1 Never Married 2 Married	FORCES? 1 X YES		If yes, s	specify Cuban, Mexican S 2 NO Specify:	, Puerto Rican, atc.)		Black, White, atc. Specify:
	3 Widowed 4 Divorced				X .			White
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COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT u					
<u> </u>	17. FATHER'S NAME (First, Middle, Last)		Bus Dri	ver	10 MOVILEDIO NAM	Transpor		
Ö   W	Oscar Keller					antneyer	Sumame)	
0	19a. INFORMANT'S NAME (Type/Print)	-	19b. MAILING	G ADDRESS (Street	and Number or Rural Re		n State Zin Code	0)
ᄋ	Doris Overstreet	-			d Court,			
	20e. METHOD OF DISPOSITION		. PLACE AND DATE	OF DISPOSITION (A			CATION — City	
	1 N Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	FO	etery, cremetory or control Linco	oln Ceme	etery 05/2	5/95 Bre	ntwood.	Maryland
- 1	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE A		22, NAME /	AND ADDRESS OF FAC	ILITY		
	1 hu. 15.	/I						Home, P.A. 11e, MD 201
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE O	)F): )F):	tatic C	erci nov	ns_	6 week
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EDICAL	PART II. Other significant condition	ns contributing to daeth be	ut not resulting	In the undarlying	ng cause given in P		RMED?	AMILABLE PRIOR TO COMPLETION OF CA OF DEATH?
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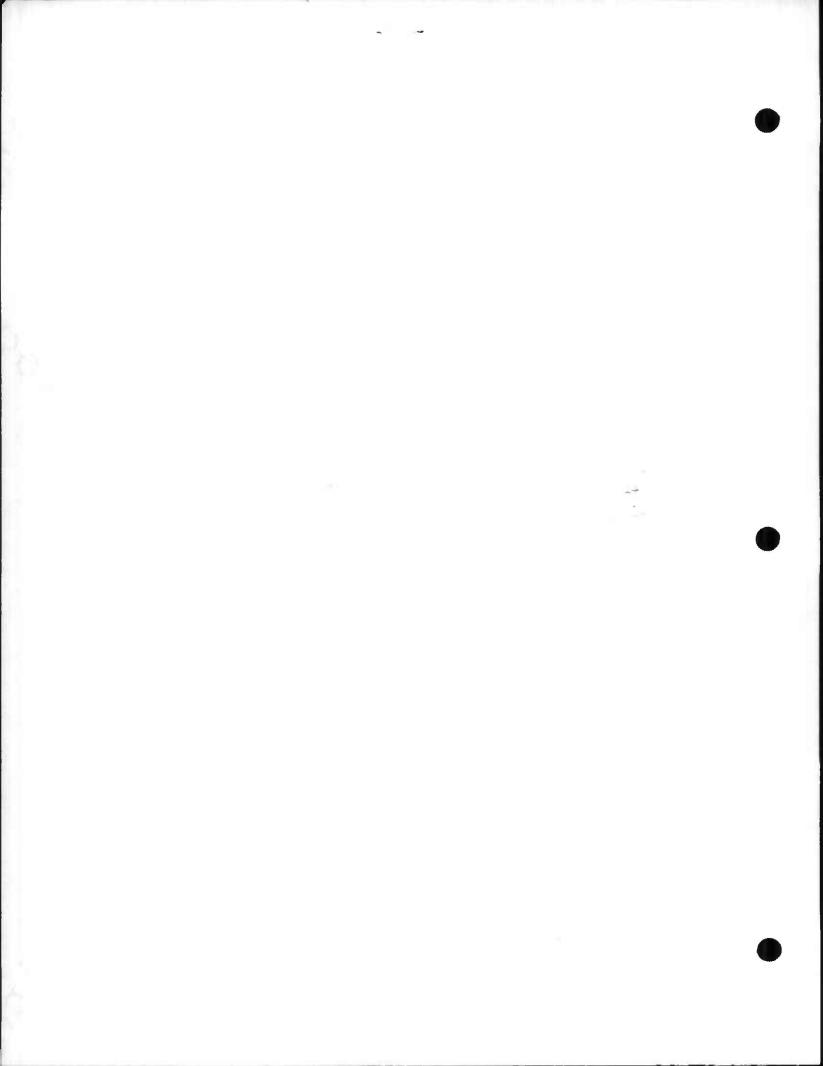
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-		4. SOCIAL SECURITY NUMBER  081-12-9033	5. SEX	6. AGE (In yrs. last	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF I (Month, De	BIRTH ly, Year)	8.	Country)	ACE (State or Foreign WYork
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OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	8	3 Suicide 6 Could not be determined	28e. PLACE Of building, e	F INJURY — At hometc. (Specify)	ne, farm, i	street, facto	ery, office			261. LOCATIO City or To	N (Street er wri, State)	nd Number or	Runii Routi	• Number,
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		JAMIE HARMS  31. DATE FILED (Month, Day, Year)	277				KA		ARN	IOLO	MD	2/20	> /	
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		1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH
		Edward James	KNOX				June	8, 1995	YEAR	12:05 P
		4. SOCIAL SECURITY NUMBER	The second second	in yrs. last birthday)	IF UNDER 1 YEAR	7	7. DATE OF I		8. BIRTH	PLACE (State or Foreign
B		215-12-2025	1 X M 2 □ F 8	8 YRS.			Mar.	24, 190		
3 should	Œ	99. FACILITY NAME (If not institution, give str				OR LOCATION OF	DEATH	9c. CO	UNTY OF O	EATH
1.2	DIRECTOR	Garrett County Me	morial Hosp:	ital	0a	kland		Ga	arret	t
Pages	E E	10a. STATE 10b. COUNTY		10c. CI1	Y, TOWN OR LOC	ATION				10d. INSIDE CITY LIMITS?
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t permit.	RAL	104. STREET AND NUMBER			1	Of. ZIP CODE		10g. C	TIZEN OF W	YHAT COUNTRY?
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215-0020 attending physician. se as the burial-trar	BĄ	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DA	ITES	1 - YE	ES 2 X NO Spec	#y:		Specif	White
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The hospital detached to once.	COMPL	5		Machin	e Opera			one Quar		
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	입	Deloris Farmers				UpperMai				1770
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IMORE, Page 6 may be al director, page		1 🗵 Burial 2 🗆 Cremetton 3 🗆 Remort 4 🗆 Donation 5 🗆 Other (Specify)	val from State CA/2	etery, crematory or clendale	Cemeter	У	6/12	Swanton		
ALTIN death. Pag tuneral dii tuneral dii examiner		21. SIONATURE OF FUNERAL SERVICE LICE			22. NAME	AND ADDRESS OF F	ACILITY		,	утана
ALTI death. P funeral examin		> Bulle X X	Moud		Ster	wart Fune S. Second	ral Ho	me	) (D)	21550
hours after d ed in by the or removal.		23. PART i. Enter the diseases, or co	mplications that caused	the death. Do	not antar tha m	oda of dying, su	ch ss cardiac	or respiratory a	rrest,	21550 Approximats
3 6 g 6		shock, or haart failura. L iMMEDIATE CAUSE (Final	ist Dnly Dne ceuse Dn ea	ich ilna.						Interval Between Onset and Death
ely fille nation,		disesse or condition resulting in death)	Prostat	ic Carc	inoma wi	ith metas	tasis			Months
ompletely or crema event,			DUE TO (OR AS A	CONSEQUENCE O	F):					Honens
executed with and complet b burial, cren	N	Sequentially list conditions, b.		ive Hear		ıre				Years
or t	RTIFICATION	if any, leading to immedista cause, Enter UNDERLYING	DUE TO (OR AS A							
ertificate ing physical price	윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	SECONOS CONSEQUENCE O	ary to r	one marr	ow meta	astasis		Weeks
· o by	F	resulting in dasth) LAST								į
" 5 4 3	. CE	PART ii. Other aignificant conditions	contribution to death by	.44						
res that the signed by the leatth and M	CAL	Act ii. Otter arginicant conditions	contributing to death be	ot not rasulting	in the underlyii	ng cause given ir	1 Part I.   24s	PERFORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
requires that seen signed by of Health are shown any	EDIC						10	YES 2 X NO		OF DEATH?
	M	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	F DEATH Y	S I NO I	XI LINICEDTAL				1 TES 2 NO
AN: The law fificate has to State Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEA						
AN: The life to State to State	SIC	EXAMINER?	HOSPITAL:	etient 3 🗆 DOA	OTHER:	me 5 🗆 Residence	6 Other (So	ec(fv)		
NSICIA S certii ith the	H	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. IN	JURY AT	_	BE HOW INJURY O	CCUREO	
NG PHYS ther this cath with	ВУ	1 X Natural 5 Pending 2 Accident Investigation	(			YES 2 NO				
J 5 4 5	ED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm,	street, factory, offi	lce	28f. LOCATIO City or To	N (Street end Numb	er or Rural R	oute Number,
OR ATTENU OR ATTENU DIRECTOR: hours after										
AL OR AL OR AL ORES	COMPL	29e. CERTIFIER (Check only one)	AN: To the best of my knowle	edge, death occurr	ed at the time, dat	te end place, end du	e to the cause(e	and manner es st	sted.	
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 hc	S	2 MEDICAL EXAMINER	On the basis of examination	end/or investigation	on, in my opinion,	death occured at the	e fime, date end	place, end due to	the cause(e)	and menner es stated.
THE H	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	101	20		29c. LICENSE NU	MBER	29d. DA	TE SIGNEO	(Month, Day, Year)
2 6 3 ₹	5	30. NAME AND ADDRESS OF PERSON WHO	J our		21.0	H26	154		6/8	/95
						D. 10-				
		Dr. P. Daniel Mill 31. DATE FILED (Month, Day, Year)	32 AREGISTRAR'S SIGNA	TUDE	riaza,	Kt. 135-	E, Oakl	and, MD	215.	50
		JUN 9 1995	Julia otheroles	harlall						

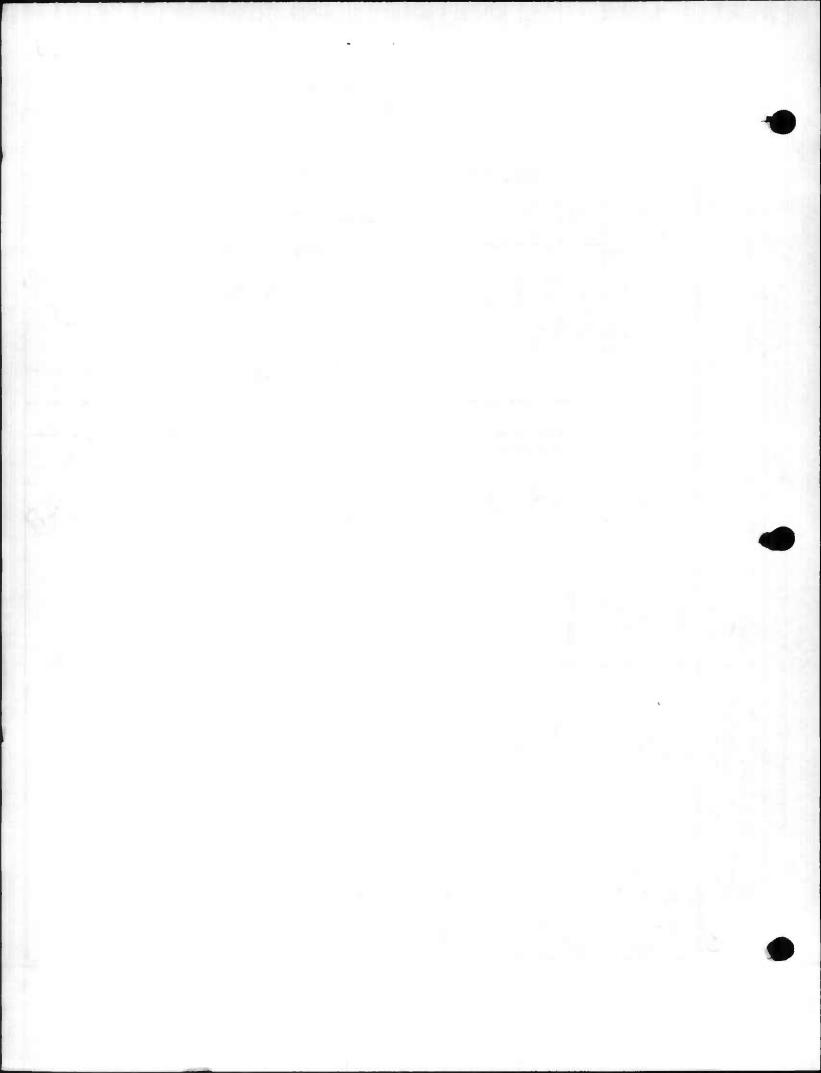


		REGISTRAR		CE	RTIF	CATE O	F DEATH		REG. NO	).		
		1. DECEDENT'S NAME (First, Middle, Last						MONT	OF DEATH	AY	YEAR	3. TIME OF DEATH
		Stella	- KONT					Ma	7 28,	1995		5:54 P M
		4. SOCIAL SECURITY NUMBER		L AGE (In yrs. last	t birthday)	IF UNDER 1 YEAR		7. DATE	OF BIRTH		Country)	LACE (State or Foreign
2		371-31-5052	1 🗆 M 2 🛱 F	96	YRS.	MONTHS DAYS	HOURS MIN,	Aug	2, 1	898	Gree	ce
3 should	-	9e. FACILITY NAME (If not institution, give				9b. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUNT	Y OF DE	ATH .
2, 3	DIRECTOR	Garrett County	Memorial H	ospital	L [	(	Dakland				Garr	ett
·	5	RESIDENCE OF DECEDENT  100. STATE 100. COUN	ENT  LOUNTY 10c. CITY, TOWN OR LOCATION								_	
Pages	E	MD NO. COOK			10c. CITY						1	IOd, INSIDE CITY LIMITS?
permit.		10g, STREET AND NUMBER	Garrett			0aklar						XYES 2 NO
	RAL	604 Hamill Stre					101. ZIP CODE			10g. CITIZE	N OF WH	IAT COUNTRY?
an. trans	FUNER						21550				USA	
21215-0020 al or attending physician. for use as the burial-transit	BY FU	11. MARITAL STATUS  1 Never Merried 2 Merried  3 XWidowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 N	MED IO	If yes,	ECENDENT OF HISPA specify Cuben, Mexico ES 2 PNO Specif	en, Puerto	N? (Specify Ye Rican, etc.)	s or No—	4. RACE - Black, Specify:	- American indian, White, atc. White
1215-0 r attending use as the	8	15. DECEDENT'S ED		16a. DEG	CEDENT'S	USUAL OCCUPA	TION	160	. KIND OF BU	SINESS/INDU	STRY	
212 al or a for us		(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ve kind of w Do NOT use	rork done during i e retired.)	most of working		0.000			
Spita D	.   로	3		_	Hou	sewife			Н	ome		
YLAND 2 by the hospital be detached fo	once. COMPLET	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	AME (First,				
2 2 2	Till 10	John	Spirid	oulas			Constan	ntine		,		Demas
MAR retained 5 should	2 0	19e. INFORMANT'S NAME (Type/Print)			. MAILING	ADDRESS (Stree	t end Number or Rural			n. Statu. Zin C		Demas
≥ 5 v		Theodore Lascar	is									561
may be	2	204 METHOD OF DISPOSITION	Theodore Lascaris    656 White Oak Dr., Swanton, Maryland 21561   A. METHOD OF DISPOSITION   DATE   20c. LOCATION — City or Town, State   Camellon, Competent, Competent or other place)   DATE   20c. LOCATION — City or Town, State									
O 6 5	E ST	4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cametery, cmr	metory or ott			5/3		troit,		
Page a		21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE				AND ADDRESS OF FA		T De.	LI OIL,	1110	IIIgaii
BALTIM ter death. Page the funeral direct	examiner	> Bralley R	Goodle.			Ste 32	wart Fune S. Second	ral St.	Home , oakl	and, l	MD	21550
hours after ed in by the or removal	medica	23. PART i. Enter the diseases, or shock, or heart fellure	complications that c	eused the de	eth. Do n	ot enter the n	node of dying, suc	h as car	diac or reap	iratory arrea	it,	Approximata
filled is		IMMEDIATE CAUSE (Finel	. Clet Only One Cause	on each line.								Onset and Death
- A	. a	disease or condition resulting in death)	acute my	vocardi	al in	nfarcti	on					l hour
A vitt	event,		DUE TO (OF	R AS A CONSEO	UENCE OF	):	<u> </u>					1 mout
		Sequentially list conditions	b									
	y, or other traumatic	Sequentially list conditions, if any, leading to immediate	DUE TO (OF	R AS A CONSEO	UENCE OF	):						
	2 3	CAUSE (Disease or Injury	c									
ding p	TIE!	that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSEO	UENCE OF	):						
ath cath			d									
	-31	PART II. Other eignificent condition	ns contributing to de	eth but not re	sulting in	the underly	ing cause given in	Part i.	24a, WAS AN	AUTOPSY	1 24h W	/ERE AUTOPSY FINDINGS
7 = 5 5	EDICAL								PERFOR		A	MAILABLE PRIOR TO
ires the signed teatth a	E B							_	1 TYES 2	M NO		F DEATH?
v requir	Shows	DID TOBACCO USE CON	TRIBLITE TO CALL	CE OF DEAT	FLI VE		T III ICEDIA				1	YES 2 NO
AL has t	AN	25. WAS CASE REFERRED TO MEDICAL	T CAUS			H (Check only on		ИП				
- F 2 2	SICIAN:	EXAMINER?	HOSPITAL:			OTHER:						
SICIAN: The State the State	의 수	27. MANNER OF DEATH	28e. DATE OF IN.		28b. TIME		ome 5 🗆 Residence	_				
DING PHYS After this death with	marked BY Pt	1 💢 Natural 5 🗌 Pending 2 🗍 Accident Investigation	(Month, Day,	Year)	INJU	JRY W	VORK? YES 2 NO	200. DE	CRIBE HOW I	NJURY OCCU	RED	
TTENDI TOR: A after de	<u></u> □	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF II building, etc	NJURY — At hon c. (Specify)	ne, ferm, st	reet, factory, off	lice	28t. LOC City	ATION (Street or Town, State)	and Number or	Rural Rou	te Number,
DIRIC	PLET	290. CERTIFIER 1 X CERTIFYING PHYS	SICIAN: To the best of my	knowledge des	eth occurre	d at the time de	to and place and due	40.40				
N N N	-   5	(Check only one) 2 MEDICAL EXAMIN	ER: On the basie of exam	nination and/or in	westlastion	. In my pointon.	death occured at the	time dete	sede) end mai	d due to the		and common an advanta
HOSPITAL FUNERAL WITHIN 72	N S	296. SIGNATURE AND TITLE DE CERTIFIE			NO PAREL	10, 1007, 14,0000			one piece, en			
물물을	BE CO	Alle	Cu 2				DOOD 1 1	MBER		29d. DATE S	IGNED (N	forth, Day, Year)
663	일	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE	OF DEATH (ITCH	27) (5	Deint	D39811			Mag	,50,1	1995
		Dr. Jerry Adams					Oakland,	MD	21550	0		
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE		-						
	U	JUN 8 1995	Teli Stood	sor Rods	M							



DALIMONE, MANIENIE	ours after death. Page 6 may be retained by the hosp	filled in by the funeral director, page 5 should be detache ion, or removal.	he medical examiner must be notified at once.
60.00 00 100 000 000 000 000 000 000 000	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Fours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Heath and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumstic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MA					EALTH AN	D MENTA	AL HYGIEN	E			
1000	1. DECEDENT'S NAME (First, Middle, Last)  Betty Doris	Lee	KIGH'	r				2. DAT MON JUI	e of DEATH	995	EAR	10:45 P M	
	4. SOCIAL SECURITY NUMBER 232-22-3738  9a. FACILITY NAME (If not institution, give a	1 🗆 M 2 📉 F	74	YRS.	MONTHS	DAYS	HOURS ME	May	E OF BIRTH  1th, Day, Year)  7, 192	1 W	est	Virginia	
TOR	804 M Street				CPC.		ake Pa			Ga:	rret		
DIRECTOR	10e. STATE 10b. COUNT	v Garrett		120.00	Y, TOWN C		Park			10d. INSIDE CITY			
	10e. STREET AND NUMBER	Jarrett		1 11			ZIP CODE	550			1 ♣ YES 2 NO 10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	804 M Street 11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	IMED	13.	WAS DEC	ENDENT OF HI	550 SPANIC ORIG	IN? (Specify Yes			- American Indian,	
B	1 Never Married 2 A Married 3 Widowed 4 Divorced	IF YES GIVE WAR OR DATES					2 NO S		Rican, etc.)		Specify:	White White	
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(G	CEDENT'S live kind of v Do NOT us	work done	CCUPATIO	IN st of working	16	b. KIND OF BUS	INESS/INDUS	TRY		
COMPL	12 17. FATHER'S NAME (First, Middle, Last)			Но	usew	ife			Home				
	Samuel Fletch	ner Ca	lvert					S NAME (First, S1e	Middle, Malden	Surname)	Mav	field	
O BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Number or R	ural Route Nur	nber, City or Town	, State, Zip Co	-		
	Alfred J. Kight		1					ke Par	rk, Mar	-		550	
	20a, METHOD OF DISPOSITION  1	oval from Stata	cometery, cre Garret	metory or of	ther place) Me	m. G	me of ardens	DA		land,			
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE				Stew	art Fu. 2nd.	neral	Home Oaklan	d, MD	21	550	
CERTIFICATION	23. PART I. Enter the diseases, or shock, or heart feilure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	Metasi  DUE TO (0	DO BEACH LINE  THE AS A CONSECUTE  THE AS A CO	Teasi	t Car		or or owner,	over as can	uac or respin	atory arreed		Approximate interval Between Onset and Death 4/93	
MEDICAL	PART II. Other eignificant condition Atrial Fibrill		eath but not r	esulting (	n the un	derlying	cause giver	in Part i.	24a. WAS AN / PERFORI	WED?	A C	YERE AUTOPSY FINDINGS WALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF DEATN	(Check only o	nne)				
2	1 YES 2 NO	1 Inpatient 2 E			4 🗆 Nun	ing Nom	5 A Reelder						
	1 Netural 5 Pending 2 Accident Investigation	(Month, Day,	Ybar)	28b. TIMI INJ	URY M	28c. INJI WO 1 Y			SCRIBE HOW IN	JURY OCCUR	IED		
מ	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF I building, etc	NJURY — At ho c. (Specify)	me, farm, s	treet, fact	ory, office		28f. LO	CATION (Street el or Town, State)	nd Number or I	Rural Rou	rte Number,	
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE										Ruse(a) s	and manner as stated.	
מפ	29b. SIGNATURE AND TITLE OF CERTIFIER	of a	Ku	in	ns	0	29c. LICENSE D266.				GNED (N	Aonth, Day, Year)	
	30. NAME AND ADDRESS OF PEASON WH Dr. Margaret Kais		PO Box			79 (	Garrett	High	way 0a	akland	MD	21550	
5	31. DATE FILED (Month, Day, Year)  JUN 7 1995	Jalia Dan	S SIGNATURE	bell .									



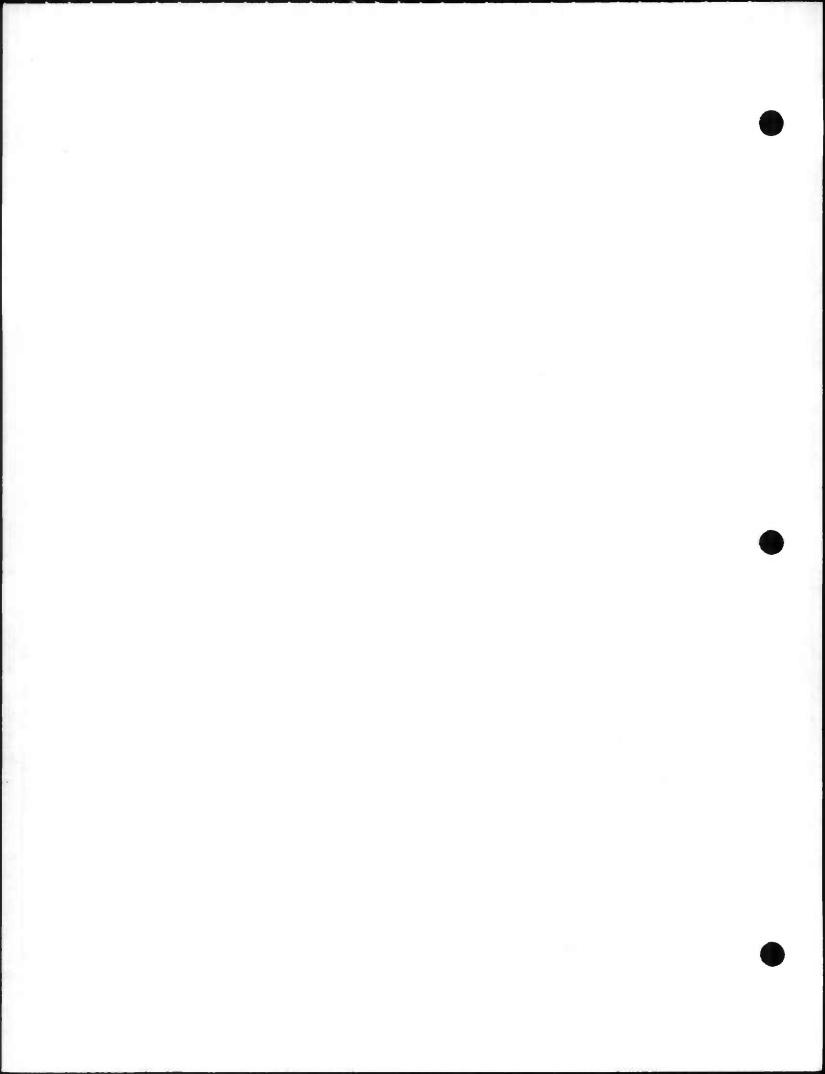
the state	det	
3	8	
PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be det	
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	RTMENT OF H	EALTH AND DEATH	MENTA	NL HYGIEN			
.6		1. DECEDENT'S HAME (First, Middle, Last)					2. DAT	E OF DEATH		YEAR 3	. TIME OF DEATH
100		MARVIN Linn			MILLER				995		1:15 A. M
Pjo		4. SOCIAL SECURITY HUMBER 235-56-3675	1⊠M2□F 61	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Nov	of BIRTH th. Dev. Year) 2 1933	•	L BIRTHPL Country)	ACE (State or Foreign W.Va
2, 3 should	OR	Memorial Hospital		nter	96. CITY, TOWN C	rland	DEATH		Alleg		TH
physician. burial-transit permit. Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  W.Va  Mine			ry, town on Locat	ПОН				1	0d. IHSIDE CITY LIMITS?  YES 2 7 NO
E-ed	\¥	10e. STREET AND HUMBER			101	ZIP CODE			10g. CITIZE		AT COUNTRY?
an. Transit	FUNERAL	Rtl Box 116				26717				SA	
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES : IF YES, GIVE WAR OR DATE	S. ARMED 2 NO S	If yes, sp	EHDEHT OF HISPA ecify Cuban, Mexic 2 HO Speci	an, Puerto		e or No 14	Black, \	- American Indian, White, etc. White
use att	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	Cation completed) 16 College (1-4 or 8+)	Sa. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mose retired.)	ON st of working	16	b. KIHD OF BU	SIHESS/IHDUS	STRY	
hospid ached	COMPL	10		Labore	er			Constr		n	
by the hospital of be detached for at once.	_	17. FATHER'S HAME (First, Middle, Lest)  Harry Kitzmille	~			Florence		Middle, Meiden Snyder	Surneme)		
5 should b	BE	190. IHFORMANT'S NAME (Type/Print)	L	19b. MAILING	ADDRESS (Street e				en State Zin Co	inefal.	
e reta	5	Jeffrey Kitzmiller				Elk Gard			26717	500)	
hours after death. Page 6 may be retrained ed in by the funeral director, page 5 should or removal.  medical examiner must be notified		20e. METHOD OF DISPOSITION 1 G Burlet 2 Gremation 3 Remo	wal from State 20b.PL	ACE AND DATE			May 3		CATION — CR		en W.Va
ins after death. Page 6 m in by the funeral director, removal.	10	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	OF CHIE	22. NAME AF	ID ADDRESS OF FA	ACILITY				en w.va
fune fune		> Wanted b	Bunda	-B		A. Burd					1538
ompletely fills if, cremation, event, the	N	iMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that caused the late only one cause on each carcinoma, K. DUE TO (OR AS A CO	idney r	ight wit				iratory arres	t,	Approximate Interval Between Onset and Daeth 4 Weeks
th certificate be ending physician I Hygiene prior t or other traus	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO								
es that the deat gned by the atte alth and Mental s any injury,	MEDICAL (	PART if. Other significant conditions	contributing to deeth but	not resulting	In the underlying	cause given in	Part I.	24e. WAS AN PERFOR	RMED?	AN CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
een si of He	ME	DID TOBACCO USE CONTR	IDLITE TO CALLER OF	DEATH 1	C [] 110 [	1111-12				1	YES 2 NO
has b Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)	UNCERIAI	иП				
State	SIC	EXAMINER?	HOSPITAL:		OTHER:	5 - Residence	6 □ Oth	er (Specific)			
is cert for the	РНҮ	27. MANNER OF DEATH	28a. DATE OF IHJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ		_	SCRIBE HOW II	NJURY OCCUP	RED	
NG Ph ther th mark	ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO					
ECTOR: A rrs after de	ED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF IHJURY — building, etc. (Specify)	At home, ferm,	etreet, factory, office		28f. LOC City	ATION (Street a or Town, State)	and Number or	Rural Rout	te Number,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that 1 TO THE FUNERAL DIRECTOR: After this certificate has been signed by be filed within 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any I	COMPLET		CIAN: To the best of my knowledge t: On the basis of examination an								nd manner as stated.
D THE HO D THE FU e filed wit	3E	29b. SIGNATURE AND TITLE OF CERTIFIER		<del></del>		29c. LICENSE NUI	MBER				onth, Day, Year)
FFA	5	30. HAME AND ADDRESS OF PERSON WHO				D 23371			7.1.5	+	. , , ,
	ļ	31. DATE FILED (Month, Day, Year)	Son Heights Me Kent Avenue 32. MEGISTRAR'S SIGNATU	ROA	Building Land, Md	Suite 21502	2102				
		JUN 6 1995	The state of	Markell							

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after cleath with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.  MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARY	YLAND / DEPAR CERTIF	TMENT (	F HEALTH	AND ME	ENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH		3. TIME OF DEATH
	COWAN	BELL		KEN	NERLY		MAY 30		4:40 A M
	4. SOCIAL SECURITY NUMBER 212-24-1527	5. SEX 6. AC	GE (In yrs. last birthday) 68 YRS.	IF UNDER 1 Y	EAR IF UNDER	MIN.	Month, Day, Year)	8. BIF Cod	HTHPLACE (State or Foreign intry)
_	9a. FACILITY NAME (If not institution, give atr				WN OR LOCATI			9c. COUNTY OF	DEATH
DIRECTOR	Sacred Heart Hos	pital		Cumb	erland			Allega	ny
EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR I	OCATION				10d, INSIDE CITY
	Maryland Allega	ny	Lona	aconin	g				LIMITS?
FUNERAL	10a. STREET AND NUMBER BOX 52				101. ZIP COD	E		USA	F WHAT COUNTRY?
N	11. MARITAL STATUS	12. WAS DECEDENT EVE		13. WAS	DECENDENT (	OF HISPANIC	ORIGIN? (Specify Yes		ACE American Indian.
	1 Never Married 2 Married	FORCES? 1 X YE		If ye	e, specify Cubs	ın, Mexican, F	Puerto Ricen, atc.)	BI	eck, White, etc.
D BY	3 🔀 Widowed 4 🗌 Divorced	WWII						"	Mite
E	15. OECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	16a. DECEDENT'S (Give kind of a	USUAL OCCU	PATION og most of workin	ng	166. KIND OF BUS	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Casting				Foundry		
MO	17. FATHER'S NAME (First, Middle, Last)		Cabelin		16 MOT	HER'S NAME	(First, Middle, Maiden	Sumama)	
BE C	unknown						Bell	Surrainey	
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	AODRESS (St	reet and Number	or Rural Rout	te Number, City or Town	n, State, Zip Code)	
ř	Vicki L. Shockey		8503 I	3, Ell:	icott (	City, M	id. 21043	(Falls	Run Road)
	20a. METHOD OF DISPOSITION 1 1 Burial 2 Cremation 3 Ramon	val from State	10b. PLACEAND DATE	OF DISPOSITIO				CATION — City or	
	4 Donation 5 Other (Specify)		Philos Cen		JL IE AND ADDRE			ternport	,Md. 21562
	• ()5	m. K.		Eic	nhorn-1	4cKenz	zie Funera	al Home	
	23. PART I. Enter the diseases, or co	omplications that cause	sed the deeth. Do r	Lon	aconing	g,Md.	21539	entani amont	l Account
	immediate cause (Final disease or condition resulting in death)	A Quit I	dispattions  A CONSEQUENCE OF	Apea	uding	Spin	al Cord by	neliti	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		M ROPLOM S A CONSEQUENCE OF	ut	noces	i co	nidered)	, wit	
	PART II. Other significent conditions	contributing to deeth	but not resulting i	n the under	lying couse g	lven in Par		Trans.	4b. WERE AUTOPSY FINOINGS
PHYSICIAN: MEDICAL							PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME									OF DEATH?
ÿ	DID TOBACCO USE CONTRI	IBUTE TO CAUSE	OF DEATH YE	S I NO	□ UNC	ERTAIN	V		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only OTHER:	one)				
1YS	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/O		4 - Nursing			Other (Specify)		
ВУ Р	1 Matural 5 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year		URY	WORK?		Id. OESCRIBE HOW IN	IJURY OCCURED	
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJU building, etc. (S	RY — At home, lerm, a pecify)	treet, factory,	office	28	If. LOCATION (Street a. City or Town, State)	nd Number or Rura	l Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI DESCRIPTION 2 MEDICAL EXAMINER:	AN: To the best of my kno	owledge, death occurre	d at the time,	data and place, on, death occur	end due to I	the cause(a) and man	ner as stated. I due to the cause	o(s) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	e C. D	sign	m	29c. LICE	NSE NUMBER		29d. DATE SIGNE	ED (Month, Dey, Year) - 30 - 95
F	Wayne C Spigo	le MD 0	112 Seto	Print) nDri	ve Ci	umbe	rland 1	MD 213	502
	31. DATE FILED (Month, Day, Ybar)	32. REGISTRAR'S SIG	SNATURE		1		,		
	HIN 0 2 1995	Julia Dancisa	N-MANUAL						



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29b. SIGNATURE AND TITLE OF CERTIFIER

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95 18563 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATN May 30, William C. Keiling 1995 5:50 A.M. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morth, Day, Year) Deca 23, IF UNDER 1 YEAR | IF UNDER 24 HRS B. BIRTNPLACE (State or Foreign Maryland 217-10-4366 1 🕅 M 2 🗆 F 81 DAYS HOURS YPS 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Allegany Frostburg DIRECTOR 11413 Upper Georges Creek Rd. S.W. RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Allegany Frostburg 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 11413 Upper Georges Creek Rd. S.W. 21532 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BΥ Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Bowling Lanes Owner & Operator 8 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) John Keiling Isabel Dudley BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 11413 Upper Georges Creek Rd. SW, Frostburg, Md. Edna V. Keiling 20s METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Frostburg Memorial Park 6/1 Frostburg. Md. Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532 23. PART. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Prostate CA Muaxano Unerm resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PHYSICIAN: MEDICAL PERFORMED? 1 ☐ YES 2 ☐ NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED Natural Accident 5 Pending Investigation ВУ 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 8 Could not be 4 Homicide datermined ᆸ CERTIFIER (Check only one)

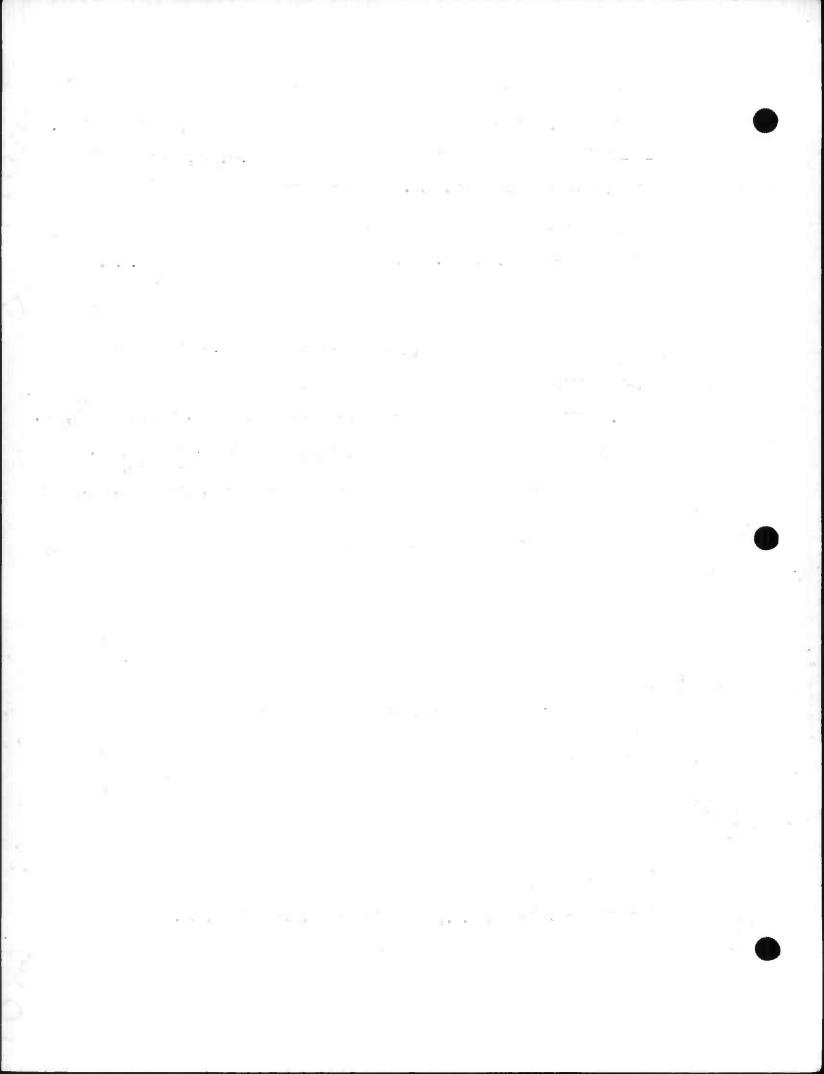
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. COMPL

44712 annette 5311 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nannette Mc Cullouch M.D. 902 Seton Drive, Cumberland, Md. 21502 31. DATE FILED (Month, Day, Year)
MAY 3 1 1995 In Struction Rawfall

2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)



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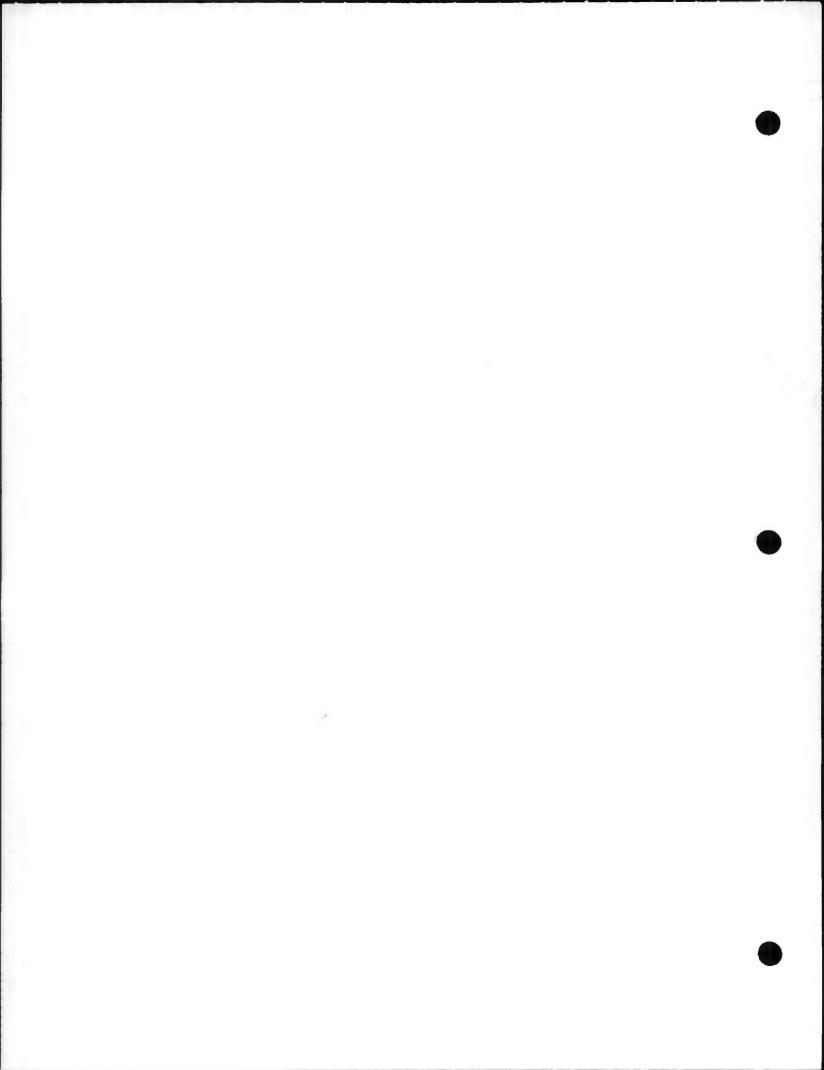
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH JOHN EDWARD KELLY 25 May 1995 1:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) August 25 e. BIRTHPLACE (State or Foreign Country)
US, Marylane IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 723~14-8092 1X M 2 F 73 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Paul Tasker Nursing Home 0akland Garrett RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Allegany Westernport 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 269 Main St. 21562 US Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married 2 NO 1 TYES 2 THO BY 3 Widowed 4 Divorced Specify: Specify: WW 2 White 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elamentary/Secondary (8-12) College (1-4 or 5+) Unknown Paper Manufacture Westvaco Employee 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) to John W. Kelly BE Alice Morgan notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lula Kelly 14210 Walter Drive, Cumberland, Md.21502 Pe 20a. METHOD OF DISPOSITION DATE 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF OISPOSITION (Name of 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Speek) must Saint Peter's Cemetery 5+27-95 Westernport. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY within 24 hours after death. Boal Funeral Home 111 Church St. Westernport, 14d. completely filled in by the 23. PART I. Enter the dispases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximats Interval Batween shock, or haert fallure. List only one ceuse on sech line. 6 IMMEDIATE CAUSE (Finsi Onset and Death the disease or condition Cerebro-Vascular Accident event, Sudden resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Se burial, Hypertensive Arteriosclerotic Cardio-Vascular Disease 10 years traumatic CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 9 the attending physician Mental Hygiene prior to If any, leading to immediate prior ceuse. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST 6 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Health and PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 💆 UNCERTAIN 🗆 PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only on item certificate h HOSPITAL: 1 YES 2 - NO OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4X Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED death with 1 X Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: Jours after of 4 Homicide 28 item 29a. CERTIFIER

(Chart only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 8 FUNERAL within 72 t MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITE
TO THE FUNERA
De filed within 7
IMPORTANT: I 296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D 05658 May 25, 1995 2

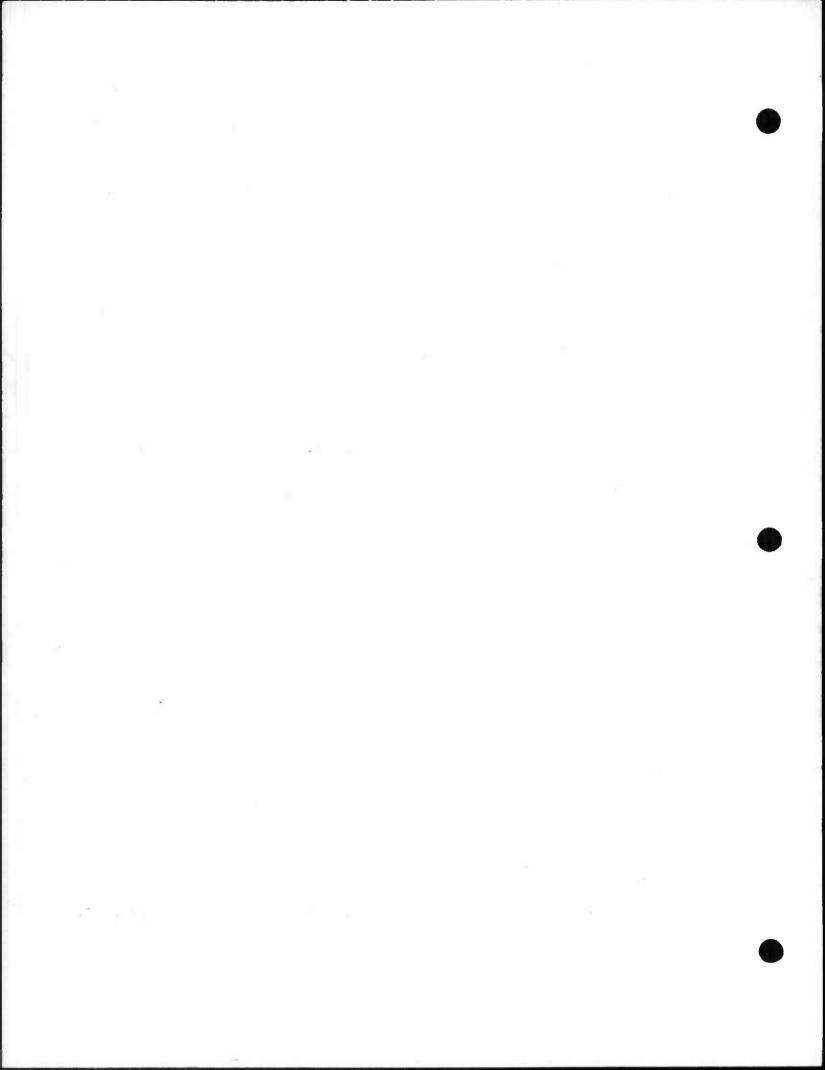
Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland

32. REGIŞTRAR'S SIGNATURE Davidson-Randall

31. DATE FILED (Month, Day, Year,



	nended #/, FOR 1. STATE REGISTRAR		ARYLAND /	DEPAR ERTIF	TMENT OF I	HEALTH AND DEATH	MENTAL H	YGIENE EG. NO.	0	
	1. DECEDENT'S NAME (First, Middle, Las	,					2. DATE OF D	EATH DAY	YEAR	3. TIME OF DEAT
	VICTORIA LUTEO  4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. let	at hirthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	MAY 7. DATE OF B		995	0650
	219-02-6077	1 M 2 X F	83	YAS.	MONTHS DAYS	HOURS MIN.	June 3.	Year)	Country	PLACE (State or Fo ) ivia
	9e. FACILITY NAME (If not institution, give	e street end number)			9b. CITY, TOWN	OR LOCATION OF			TY OF DE	
5	Washington Adve	ntist Hospi	ital		TAKOMA	PARK,	MARYLANI	TOM C	GOME	RY
DIRECTOR	10e. STATE 10b. COUN	YTY		10c. CITY	Y, TOWH OR LOCA	TION				10d. INSIDE CITY
		ntgomery		Take	oma Park	ζ				1 X YES 2
LOISENAL	100. STREET AND NUMBER 501 Domer Avenue	e #101			10	X. ZIP CODE				HAT COUNTRY?
	11. MARITAL STATUS	12. WAS DECEDENT E	EVER IN U.S. AR	RMED	13. WAS DE	20912 CENDENT OF HISP	ANIC ORIGIN? (So		ivia	— American Indie
	1 Never Merried 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 [	YES 2X		If yes, s	pecify Cuben, Mexico	cen, Puerto Rican,	atc.)	Black, Specify	White, etc.
	15. DECEDENT'S EC	DUCATION	100				Bolivi			White
	(Specify only highest gra	College (1-4 or 5+)	(G	ECEDENT'S Sive kind of w D. Do NOT us	USUAL OCCUPATI vork done during m e retired.)	ost of working	18b. KINC	OF BUSINESS/IND	USTRY	
20111	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4	Hom	nemake	er		Owr	1 Home		
	17. FATHER'S NAME (First, Middle, Last)	D:-					AME (First, Middle,	Maiden Surname)		
	Delfino  19a. INFORMANT'S NAME (Type/Print)	Pino		h MAII ING	ADDRESS (Street	Trinida		Pino	Ieh	azo
	Mauricio C. Rod	riquez	1	-	as #10	and Number or Hura	I Houte Number, Cl	ty or Town, State, Zip	Code)	
	20e. METHOD OF DISPOSITION  1  Burlai 2 X Cremetion 3  Re		20b. PLACE	ANDDATEC	F DISPOSITION (N	eme of	DATE	20c. LOCATION — C	alty or Tow	rn, State
	4 Donation \5 Donation \( \square \text{Other (Specify)} \)		Ches	apeal	<u>ke Crema</u>		5-31	Beltsvi	lle,	MD
-	21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE				Funeral		е РА		
	Dit - 15	Cal		0827				Spring.	***	00040
	23. PART i. Enter the diseases, or shock, or heart failure	r complications that c			303 (	IST AVE	PITAGE	_ obt.rud*	MU	20910
	and any are mounte familiary	e. List only one cause	aused the de	ath. Do n	ot entar the mo	oda of dying, su	ch ss cardiac o	or reapiratory srre	mD eat,	Approxima
	IMMEDIATE CAUSE (Final	e. List only one cause	on each line	<b>)</b> .	ot entar the mo	oda of dying, su	ch ss cardiac d	or reapiratory srre	at,	Approxima
		e. List only one cause	on each line	<b>D.</b>	ot entar the mo	oda of dying, su	ch ss cardiac d	or reapiratory srre	at,	Approxima
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	e. List only one cause	on each line	<b>D.</b>	ot entar the mo	oda of dying, su	ch ss cardiac d	or reapiratory arre	at,	Approxima
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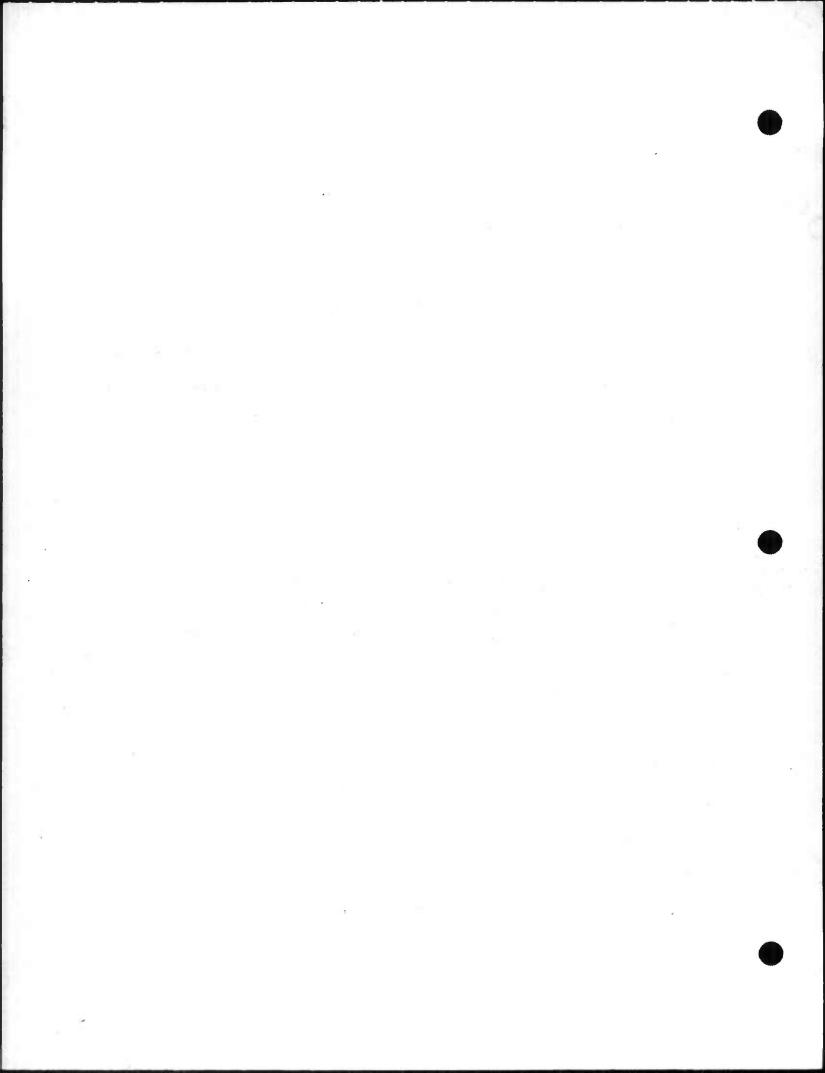
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR		SIAIE UF I	MARYLAND C	/ DEPAR ERTIF	ICAT	E OF	DEAT	AND I	MENT	REG. NO.	E		
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	4. SOCIAL SECURITY NUMBER 265-74-5669		5. SEX 1 M 2 XF	6. AGE (In yrs. In	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DAT	re OF BIRTH onth, Day, Year) ril 30,			PLACE (State or Foreign ry) Cuba
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BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. Other algnificant of  DID TOBACCO USE  25. WAS CASE REFERRED TO ME EXAMINER? 1	conditiona  CONTRIBUTION  CONT	DUE TO DUE TO DUE TO Contributing to  BUTE TO CA  MOSPITAL: 1 Xinpetient 2 Contribution 28e. DATE Of (Monto, p. 1) 28e. PLACE O building,  AN: To the best of an an an an an an an an an an an an an	(OR AS A CONSE OF DE / 26. PLA DEN/Outpatient : INJURY ay, 'ther')  F INJURY — At hetc. (Specify)  my knowledge, determination and/or	QUENCE OF DEATH ATH YE CE OF DEATH INJ DOME, ferm, a seth occurre investigation.	In the ur  In the ur  If (Check OTHEF 4   Nun  E OF URY M  Intrest, fact	NO Only one) R: aling Home 28c. INJI WOI 1 Your, office	UNC  5 S Red  JRY AT  RK7  and place, oath occurre  29c. LSICE	ERTAIN sidence ( and due to a det the to the total and the	Pert I.  1 On Carlot to the c de BER	PERFORM  1  YES 2  Ther (Specify)  ESCRIBE HOW IN  DOCATION (Street army or Town, State)  resuse(a) and many rite and place, and	JURY OCC  JURY OCC  And Number  There as state dus to the	or Rural R	WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Route Number;

32. REGISTRAR'S SIGNATURE
Film Daviden Roydall



DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should permit. use as the bunial-transit retained by the hospital or attending physician. has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. once. notified at must be examiner medical the traumatic event, or other in ury. shows any HOSPITAL OR ATTENDING PHYSICIAN: The law 23 DIRECTOR: After this certificate has hours after death with the State Dittem 28 is marked, or item TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If II

STATE REGISTRAR

DIRECTOR

FUNERAL

BY

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COMPL

BE

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

2

29 BE

1 Natural

3 Sulcide

4 Homicide

Accident

6 Could not be

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	STATE OF I	MARYLAND /	DEPAR	TMENT	OF H	IEALTH DEA	AND	MENTAL HYGIE			
(First, Middle, Last)								2. DATE OF OEATH			3. TIM
Alette :	Birgitte	Langmo						June 2	2, 19	95	5
NUMBER	5. SEX	8. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTH		a. BIRT	HPLACE
289	1 ☐ M 2 💯 F	92	YRS.	MONTHS	DAYS	HOURS	MIN.	Aug. 26,	1902	Count	NO:
not institution, give si				9b. CITY	, TOWN	OR LOCATI	ON OF D	EATH	9c. COI	UNTY OF C	DEATH
n Rivers	ide Nurs	ing Cente	er			Belc	amp			Har	for
10h COUNTY	,		40a OIT	V WOMEN	201004	1011					r -

1. DECEDENT'S NAME E OF OEATH 45 AM 4. SOCIAL SECURITY (State or Foreign 139-46-8 rway 9a. FACILITY NAME (# Lorie RESIDENCE OF 10a. STATE 10d. INSIDE CITY Maryland Harford Churchville 1 - YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 3007 Rolling Green Drive 21028 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indien, Black, White, etc. 1 Never Married 2 Married 3 🔀 Widowed 4 🗌 Divorced Specify: white 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 6+) Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Elias Stang Dorthea (u/k)Stang 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Vikestad 3007 Rolling Green Drive, Churchville, Md. 21028 20a. METHOD OF DISPUSITION
1 Donation 5 Other (Specify) 200 PCACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Terris & Co., Inc. 6/3/95 W. Chester, PA 21. SIGNATURE OF FUNERAL SERVICE I 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or haam fallure. List only one cause on sech line. Interval Between MMEDIATE CAUSE (Fine) Onset and Daeth disease or condition nemon, a resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART, ii. Other significant conditions contributing to death but not requiting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \square\) UNCERTAIN \( \square\)

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO 1 Dinpetient 2 ER/Outpetient 3 DOA irsing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH

28a. DATE OF INJURY (Month, Day, Year) 28b, TIME OF

26c. INJURY AT WORK? INJURY м 26a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)

28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

29a. CERTIFIER	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the ceuse(s) and manner as stated.
	CENTETTING PHYSICIAN: 10 the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
one)	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

b. SIGNATURE THE ZITLE OF CERTIFIER		29c. LICENSE NUMBER
5/1/00	Pa	439000

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATUR

29d. DATE SIGNED (Month, Day, Year)

26t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

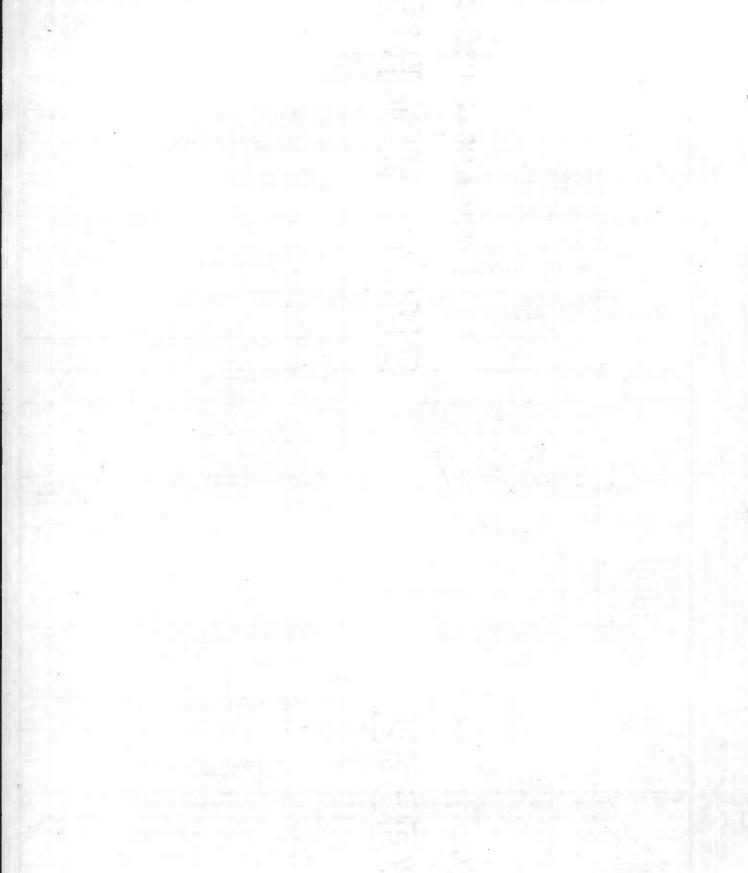
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Couns after death. Page 6 may be retained by the hospital care to death of the signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

FOR 1 - STATE PEGISTRAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR			<u> </u>	CATE U	PEAIII	REG. NO	J.		
		1. DECEDENT'S NAME (First, Middle,	Last)					2. DATE OF DEATH			3. TIME OF DEATH
		Rov Wallas		LA	W			100	4, 19	YEAR	12:15 P.M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	4, 13		PLACE (State or Foreign
		222 20 0442	1 [文M 2 □ F	68		MONTHS DAYS		(Month, Day, Year)		Country	γ)
	1 1	233-38-9441		00	1110.			April 6.1			Virginia
	ایا	9e. FACILITY NAME (If not institution,					OR LOCATION OF	DEATH		INTY OF DE	
	8	13703 Fountair				Oce	an City		Wor	ceste	er
	ECTO	RESIDENCE OF DECEDEN							-		
	12	10e. STATE 10b. CO				TOWN OR LOC					10d. INSIDE CITY
	E E	Maryland Wo	rcester		0c	ean Cit	:y				LIMITS?
	1	10e. STREET AND NUMBER					10f. ZIP CODE		10a CIT		VHAT COUNTRY?
	ERAL	13703 Fountair	Road				21842				States
	쀨									.ccu i	otarces
	FUN	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEDENT FORCES? 1	TEVER IN U.S. /	ARMED NO	13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes an, Puerto Ricen, etc.)	e or No-	14. RACE Black	— American Indian, , White, etc.
	BY	3 Widowed 4 Divorced		XYES 2 AR OR DATES		1 🗆 Y	ES 2 NO Spec	lly:		Specif	
			IWWII I	Korea (	Navy)					Wh:	ite
	ETEC	15. DECEDENT'S (Specify only highest	EDUCATION grade completed)	18e. I	DECEDENT'S	USUAL OCCUPA	TION	16b, KIND OF BU	SINESS/IN	OUSTRY	
	<u> </u>	Elementery/Secondary (0-12)	College (1-4 or 5+	• )		ork done during in retired.)					
,	ᅙ	12		C	wner (	Operato	or	Liquor	Stor	e and	d Restaurant
nce.	COMPL	17. FATHER'S NAME (First, Middle, Las	1)			-	18, MOTHER'S N	AME (First, Middle, Meider	Sumamei		
7		P.D. Law						Turner	,		
9	BE	19e. INFORMANT'S NAME (Type/Print)		1.	105 11411 1510	4000500 (O					
off	2	Imogene Law						Ocean City			12
90											
examiner must be notified at once		20a. METHOD OF DISPOSITION  1 X Burlet 2 Cremetion 3	Removal from State	20b. PLAC	E AND DATE O	F DISPOSITION	Name of June	9 , 999 5 200, 10	CATION -	City or Tov	wn, State le, Maryland
Ē		4 Donetion 5 Other (Specily)		Lake	mont I						
ne	1	21. SIGNATURE OK FUNERAL SERVE	E LICENSEE	1-		22. NAME	AND ADDRESS OF F	ACIUMLEE FUNC	eral	Home,	,Inc 6633
E		►C / /	MAS	1		Old	Alexande	r Ferry Roa	ad, C	linto	on, Md 20735
- S	_	1000	( Stort	To the				_			
or removal medical		23. PART/1. Enter the diseeses	or complications that ure. List pnly one ceu	caused the	deeth. Do n	ot enter the n	nods of dying, au	ch se cerdiac or resp	lratory ar	rest,	Approximate
ò E		iMMEDIATE CAUSE (Final	bre. List brily brie ceu	se Du eech III	ne.						Interval Between Onset and Death
the the		disease or condition	Hea	tom							1//
event,	H	reaulting in death)	S. DUE TO	(OR AS A CONS	EOHENCE OF	٠.					1/LYrs
bunal, cremation, atic event, the				TOU WO W COMO	SEGUENCE OF						
5 2			300 10			,					,
0 69	NO	Sequentially list conditions.	b								
2 E	TION	Sequentially list conditions, if any, leading to immediate	b	(OR AS A CONS	SEQUENCE OF						
traum	ICATION	if any, leading to immediate cause. Enter UNDERLYING	b		SEQUENCE OF						
traum	<b>TIFICATION</b>	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	bDUE TO			):					
or other traum	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury	bDUE TO	(OR AS A CONS		):					
or other traum	S	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO	(OR AS A CONS	BEOUENCE OF	):					
or other traum	S	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. DUE TO	(OR AS A CONS	BEOUENCE OF	):	ing ceuee given li	n Part i. 24a. WAS An		24b.	WERE AUTOPSY FINDINGS
and Mental hygiene prior to ny injury, or other traum	S	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO	(OR AS A CONS	BEOUENCE OF	):	ing ceuee given lu	PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
learn and Mental hygiene prior to ws any injury, or other traum	EDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO	(OR AS A CONS	BEOUENCE OF	):	ing ceuee given le	n Part i. 24a. WAS AN PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
or ream and memai hygiene prior to shows any injury, or other traum	MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO d. d. itions contributing to	(OR AS A CONS	SEOUENCE OF	): n the underlyl		1 TYES	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
or Health and Mental Hyglene prior to shows any injury, or other traum	MEDICAL CE	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other eignificent cond	b.  DUE TO good to see the see	(OR AS A CONS (OR AS A CONS deeth but not	t resulting in	the underlyi	□ UNCERTA	1 TYES	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Dept. or Health and Mental Hygiene prior to 23 shows any injury, or other traum	AN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b.  DUE TO d.  Itions contributing to	(OR AS A CONS (OR AS A CONS deeth but not	t resulting in	the underlyi	□ UNCERTA	1 TYES	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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the State Dept. of Health and Merital hygiene prior to or item 23 shows any injury, or other traum	PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conc  DID TOBACCO USE CO  25. WAS CASE REFERRED TO MEDIC EXAMINER 2  1 YES 2 NO  27. MANNER OF DEATH  Netural 5 Pending	b.  DUE TO  c.  DUE TO  d.  Itions contributing to  NTRIBUTE TO CAI  HOSPITAL: 1   Inpatient 2    28e. DATE OF (Month, Da	(OR AS A CONS  (OR AS A CONS  deeth but not  USE OF DE  26. PL  ER/Outpetlent INJURY	TATH YEACE OF DEAT	NO H (Check only on OTHER:	UNCERTA  e)  ome 5 Residence	PERFO 1 YES	NO NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
earn with the State Lept. of Heath and Merital hygiene prior to marked, or Item 23 shows any Injury, or other traum	BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other eignificent cond  DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC EXAMINER2 1 YES 2 NO 27. MANNER OF DEATH  Netural 5 Pending Investiga	b. DUE TO  c. DUE TO  d.   Itions contributing to  NTRIBUTE TO CAI  HOSPITAL: 1   Inpatient 2    25e. DATE OF (Month), Date  26e. PLACE OF	(OR AS A CONS  (OR AS A CONS  deeth but not  USE OF DE  28. PL  ER/Outpetlent  INJURY INJURY INJURY	EATH YE  ACE OF DEAT  3 DOA  28b. TIME	NO NO OTHER:  4   Nursing Hc OF 28c. II NYPY M 1	UNCERTAL  e)  pome 5 Besidence  NJURY AT  VORK?  YES 2 NO	PERFO 1 YES  8 Other (Specify) 28d. DESCRIBE HOW	RMED? NO NO	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
if dearn with the State Dept. of Health and Mental Hyglene prior to its marked, or Item 23 shows any Injury, or other traum	PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conc  DID TOBACCO USE CO  25. WAS CASE REFERRED TO MEDIC EXAMINER 2  1 YES 2 NO  27. MANNER OF DEATH  Netural 5 Pending	b. DUE TO c. DUE TO d.  Itions contributing to  NTRIBUTE TO CAI  HOSPITAL: 1 Inpettent 2  28e. DATE OF (Month, De	(OR AS A CONS  (OR AS A CONS  deeth but not  USE OF DE  26. PL  ER/Outpetlent INJURY	EATH YE  ACE OF DEAT  3 DOA  28b. TIME	NO NO OTHER:  4   Nursing Hc OF 28c. II NYPY M 1	UNCERTAL  e)  pome 5 Besidence  NJURY AT  VORK?  YES 2 NO	PERFO 1 YES	NO NO NO NO NO NO NO NO NO NO NO NO NO N	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
arter death with the State Dept. of Health and Mental hygiene prior to 28 is marked, or Item 23 shows any Injury, or other traum	ED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other eignificent cond  DID TOBACCO USE CO  25. WAS CASE REFERRED TO MEDIC EXAMINER 2  1 YES 2 NO  27. MANNER OF DEATH  Netural 5 Pending Investiga 1 Suicide 5 Could not determine the could be determined.	b. DUE TO c. DUE TO d.  Itions contributing to  NTRIBUTE TO CAI  HOSPITAL: 1 Inpettent 2  28e. DATE OF (Month, De	(OR AS A CONS  (OR AS	EATH YE  ACE OF DEAT  3 DOA  28b. TIME	NO NO OTHER:  4   Nursing Hc OF 28c. II NYPY M 1	UNCERTAL  e)  pome 5 Besidence  NJURY AT  VORK?  YES 2 NO	PERFO 1 YES  8 Other (Specify)  28d. DESCRIBE HOW	NO NO NO NO NO NO NO NO NO NO NO NO NO N	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
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BALTIMORE, MARYLAND 21215-0020	death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to buriat, cremation, or removal.	examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.	APORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

* REGISTRAR  1. DECEDENT'S NAME (First, Middle, La	nt)	ÇE	-ATTI IC	AIL OI	DEATH	2 DATE	REG. NO.			3. TIME OF DEA	TM	
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9a. FACILITY NAME (If not institution, gh	e street and number)	9	91	b. CITY, TOWN	OR LOCATION OF D			9c. COUNT		· -		
Meridian Nursin	g Center	Frederick				Frederick						
RESIDENCE OF DECEDENT  10e, STATE  10b, COU	, TOWN OR LOCATION					19d. INSIDE CITY						
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14660 Roddy Roa	d		21788				nlissa	U.S.A.				
11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARI	B. ARMED 13. WAS DECENDENT OF HISPANIC ORIGINAL If yes, specify Cuban, Maxican, Puerto							E — American Inc	— American Indian, White, etc.	
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR					en, Puerto F ly:	tican, atc.)		Speci	Mar.		
										"White		
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17. FATHER'S NAME (First, Middle, Last)	-	I IN	PISCE	Lea Nu	18. MOTHER'S N.	ME (First 4			8			
Francis A. Rodd	v				M. Flor			,				
19n. INFORMANT'S NAME (Type/Print)		196	. MAILING AD	DRESS (Street )	and Number or Rural				Code)		-	
Mary M. Lawler					load, Thu					788		
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SCHATU

Guy Fiscus

31. DATE FILED (Morith, Day, Year)
JUN 14 1995

BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH June 4, FERN LUDNICK 1995 10:55 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign (Month, Day, Year) 1 M 2 F 218-64-6079 78 Pittsburgh, PA Nov. 1916 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital Cumberland Allegany RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? PA Somerset Confluence 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? R. D. 1, Box 8 15424 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 TES 2 NO 3 Widowed 4 Divorced Specify Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retred.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp College (1-4 or 5+) Unknown Housewife once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George VanNosdeln K Victoria Orndorff BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Victor Ludnick 4100 Murphy's Run Court, Hampstead, MD 21074 Pe 20a. METHOD OF DISPOSITION
1 

↑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Hickman Chapel 4 ☐ Donation 5 ☐ Other (Specify) \_ 6/7 Mill Run, PA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Humbert Funeral Home, Inc. mas -P. O. Box 37, Confluence, PA 15424 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final Onset and Death** the disease or condition\_ resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 0 injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE any 1 TES NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, Hem HOSPITAL: OTHER: 1 TES ENO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 9 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 26c. INJURY AT WORK? marked, Netural Acciden М 1 YES 2 NO BY Investigation Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 3 Suicide COMPLETED 6 Could not be DIRECTOR: hours after item 28 is 4 Homicide CERTIFER CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h BEDICAL EXAMINED. On the beats of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and man 296. SIGNATURE AND PITE OF CENTIFIE 25c. LICENSE NUMBER SOL DATE SIGNED (NEWN, DATE) BE ▶ June D 12779

Memorial Hospital Medical Bldg. Cumberland, MD 21502

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

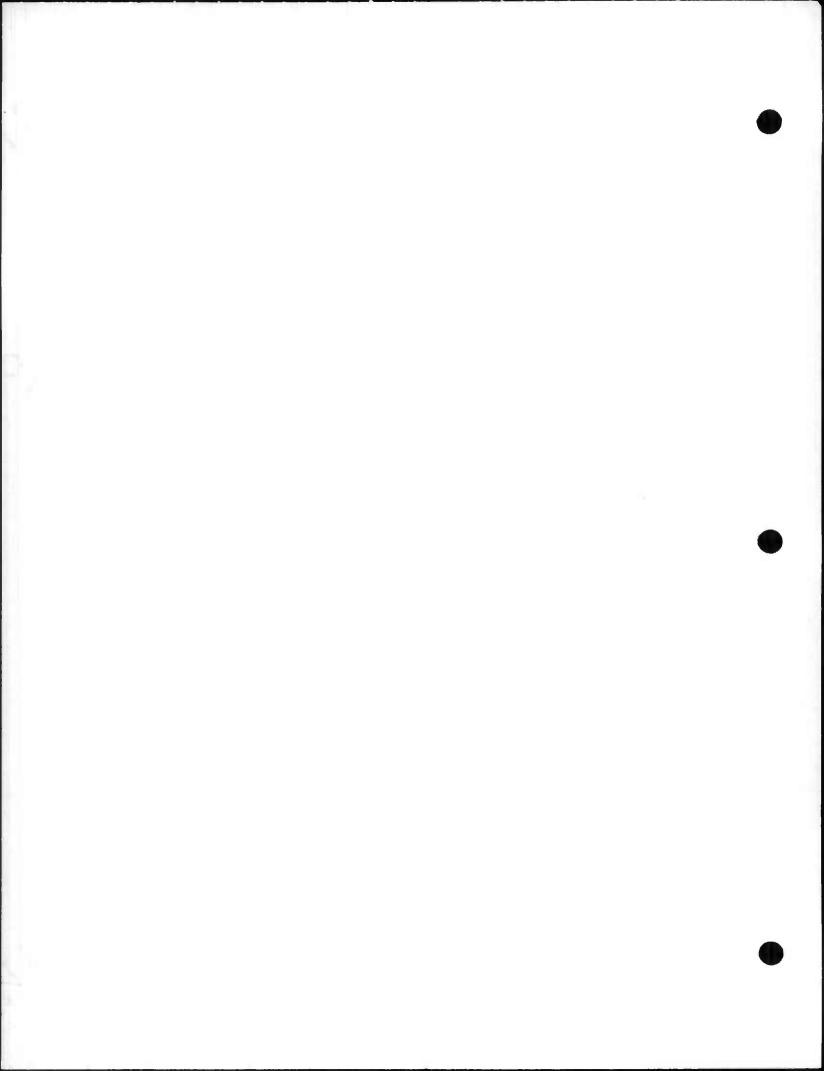
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last	MARION					2. DATE OF DEATH MONTH MONTH MAY 26 1995			
	4. SOCIAL SECURITY NUMBER	BER 5. SEX 6. AGE (In yrs. lest birthdey)			IF UNDER 24 HRS.	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign			
	216-14-9646				NTHS DAYS HOURS MIN. (Month, Day, Ye 6-17-			1924 MARYLAND		
Œ	9a. FACILITY NAME (# not institution, give PENINSULA REGI	CENTED	9b. CITY, TOWN	OF DEATH						
5	RESIDENCE OF DECEDENT	RESIDENCE OF DECEDENT				ER SALISBURY WICOM				
DIRECTOR	MD • W	ICOMICO	10c. CIT	Y, TOWN OR LOCAL SALISB			10d. INSIDE CITY LIMITS? 1 TYES 2 THO			
FUNERAL	10a. STREET AND NUMBER	10e. STREET AND NUMBER  602 BOWMAN DR •			. ZIP CODE 21801			of what country?		
S	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC		NIC ORIGIN? (Specify Ye	a or No.— 14.	RACE — American Indian		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES	ATES	If yes, sp	ecify Cuben, Mexica 2 X NO Specif		Black, Whita, etc.  Specify: WHITE			
9	15. DECEDENT'S ED	WORLD W	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BU	ISINESS/INDUST			
ᆸ	(Specify only highest gra-	College (1-4 or 5+)	Ilfe. Do NOT us	work done during mo te retired.)  R = APP		DEAT	ESTA			
COMPL	1.2 17. FATHER'S NAME (First, Middle, Last)		BROKE	ALL ALL		ME (First, Middle, Malden		1.13		
BE C	BURDELL L	LOYD			The second second second second	N BEARD	Surname)			
2	19a. INFORMANT'S NAME (Type/Print)  MARY LEE LL	OYD				Route Number, City or Tow SALISBURY				
	20e. METHOD OF DISPOSITION 1	moval from Stata cen	netary, crematory or o	ther place)			CATION - City	or Town, Stata TOWN, DEL.		
Ì	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE /	A STATE OF THE PARTY OF THE PAR		D ADDRESS OF FA		EORGE	IOWN, DED.		
	Scott	Imus		BOU	NDS FUN	IERAL HOM	E, SAL	ISBURY, MD.		
d	23 PART X Enter the diseases, or shock, or heart failure	Till only one cause on a	ach lina.			_	fratory srrest,	Approximats Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	8.			Sh	ech		Onset and Death		
_	DUE TO (OR AS A CONSEQUENCE OF):									
RIFICATION	Sequantially list conditions, if any, isading to immediate	b	CONSEQUENCE OF	F):		J				
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	E. DUE TO YOU SE A	CONSEQUENCE OF	>				9-		
E	that initiated evente resulting in death) LAST	d de la fontaga	CONSEGUENCE OF	11.				O		
S	PART II. Other algorificent condition	one contributing to deeth h	ut not resulting	n the underlying	cettee given in	Part I. 24s. WAS AN	AUTOREY	24b. WERE AUTOPSY FINDINGS		
ICAL			or not resulting	in the underlying	Couse given iii	PERFOI	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC							<b>X</b>	OF DEATH?		
A N	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL				UNCERTAI	V 🗆				
	EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:	S Decideos	6 ☐ Other (Specify)	-			
H	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26a. DATE OF INJURY 28b. TIME OF			26d. DESCRIBE HOW	W INJURY OCCURED			
2	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	RK? 'ES 2 NO					
	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, etc. (Spec	straet, factory, offic	factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
MPLE	29a. CERTIFIER (Check only one)	SICIAN: To the best of my line	ledge, death occurre	od at the time, data	and place, and dua	to the cause(a) and me	nner as stated.			
3	295. SIGNATURE AND TIME OF CUNTIFIC	NER: On the besis of examination	andier Investigatio	n, in my opinion, d						
	191	1-101	$\mathcal{I}$		D2044		29d. DATE SIGNED (Month, Dey, Year)  5/27/95			
	30. NAME AND ADDRESS OF PERSON W	ETTO Quid	11 + Kapp	Primi)	est Si	Listuny	md	21801		
	31. DATE FILED (Month, Day, Year)	Jelia Dhuelso	- Kardall				-			
	MAY 3 0 199	JENA DROUGE								

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH ANI
REGISTRAR	CERTIFICATE OF DEATH

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)	VIVIAN A. LEGRANDE					2. DATE OF DEATH DAY YEAR MAY 28, 1995			TIME OF DEATH 9:42 P.M	
/15	4. SOCIAL SECURITY NUMBER  091-03-1944		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE ( (Month,			BIRTNPL Country)	ACE (State or Foreign	
	9a. FACILITY NAME (If not institution, give	1 □ M 2 🏗 F 78	YRS.				15,	-	SOUT	H CAROLINA	
3 should	WASHINGTON ADVEN			TAKOMA	OR LOCATION OF D	PEATH 9c. COUNTY OF MONTGO					
~i   2	RESIDENCE OF DECEDENT		TAKONA				MONT	GUME.	KI		
permit. Pages 1, 2, 3 AL DIRECTOR	10a. STATE 10b. COUNT	TY		TY, TOWN OR LOC						d. INSIDE CITY LIMITS?	
	NA NA NA 100, STREET AND NUMBER		WAS	WASHINGTON, D.C.						YES 2 NO	
	5057 6th Place,	N F		,					T COUNTRY?		
bunal-transit perm	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	12 WES DE	20017 CENDENT OF NISPA	NIC OBIOINS	1.00 10 - M			TATES	
<b>6 6 6 6 6 6 6 6 6 6</b>	1 Never Married 2 Married 3 XWidowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, a	pecify Cuben, Mexic S 2 . NO Spec	en, Puerto R	(specify fee lcan, etc.)	14 OF NO.	Specify:	American Indian, filte, etc.	
. Ш	15, DECEOENT'S EDI (Specify only highest grad	JCATION completed)	16e. DECEOENT'S	USUAL OCCUPAT work done during n	ION post of working	16b.	KIND OF BUS	SINESS/INDUS			
once. COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Ille. Do NOT L	ise retired.)			_				
once.	17. FATNER'S NAME (First, Middle, Last)	2	PAIRUL	SUPERV	ISOR RET			OVERNM	ENT		
E G	ELMORE BRADFORI				18. MOTHER'S N. THERES			Surname)			
2 0	18a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural			o State Zio Co	wiel		
	GERARD LEGRANDE	(SON)			owie Way					20772	
ag ts	20a METHOD OF DISPOSITION  1/L Buriel 2 Cremation 3 Ren		b. PLACE AND DATE	OF DISPOSITION /	lame of	OATE	_	CATION - City			
er must	4 Donation 5 Other (Specify)	I	LINCOLN (	CEMETERY		6/3	SUI	TLAND	, MA	RYLAND	
al. examin	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859  M859  M859  M859  M859  M859  M859  M859  M859  M859  M859  M859  M859										
intal hydre prior to burish creation or removery.  Y, or other traumatic event, the medical CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b. CARDIO DUE TO (OR AS	ENCEPHAI	EPHALOPATHY  EQUENCE OF):  PIRATORY ARREST  EQUENCE OF):						Interval Between Onset and Death	
	PART II Other significant condition										
hows any I	PART II. Other algorificant condition						24a. WAS AN PERFOR	MED?	AM CO OF	RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO	
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or item	EXAMINER?	HOSPITAL:	patient 3 DOA	OTHER:	ne 5 🗆 Residence	6 Cother	(Specify)				
with the State Dept.  ted, or item 23 s  PHYSICIAN:	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIN	E OF 28c. IN	JURY AT ORK?			NJURY OCCUR	RED		
tem 28 is marked	1 Accident 5 Pending Investigation			M: 1 🗆	YES 2 NO						
B is	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, ferm, scify)	me, ferm, street, fectory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
2 = S	29a. CERTIFIER (Check only one)  1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.  2 🗆 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
PORTANT. BE CO	296. SIGNATURE AND TITLE OF CERTIFIE ME M. J			29c. LICENSE NUN						onth, Day, Year)	
2	20 NAME AND ADDRESS OF BERGE	H X			D24203				May 29, 1995		
	Dr.M. Yusuf, M.D. 3450 Ft. Meade Rd, Laurel, Maryland 20707										
	31. DATE FILEO (Month, Day, Year)	Julia Davelson						-			



uid be detached for use as the burial-transit permit. Pages 1, 2, 3 should ined by the hospital or attending physician, BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach.		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	ires	Sign	Healt	M.S
	requ	een	6	sho
	AR!	as b	Dept	23
	N: The	cate h	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Item
	CIA	entif	the	0
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	ND	R. Af	ar de	69
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# C	5,7 & 17,P.G.,GC,5/	31/95								9:	5	8573
	FOR 1 - STATE REGISTRAR	STATE OF M					EALTH A		NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest) PAUL FRANK	LAVEZZO								DAY 1	YEAR	3. TIME OF DEATH 4:00 A
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. las		IF UNDER		IF UNDER 24		May 23	, 1	995 8. BIRTHE	
	578-09-9755	1 📉 M 2 🗆 F	81 _63	- YRS.	MONTHS	DAYS		MIN. D	ec. 30,	1931	Wash	ington, DC
E	9e. FACILITY NAME (If not institution, give str	set and number)					R LOCATION	OF DEATH	1	9c. COL	INTY OF DE	ATH
DIRECTOR	3503 Mase Lane				Bow					Pr.	ince	George's
JIRE	Maryland Princ	Cannon	1.	1	Y, TOWN O							10d. INSIDE CITY LIMITS?
	Maryland Princ	e George	S	Mt.	. Rai		ZIP CODE			10a, CH		1 X YES 2 NO
FUNERAL	3707 37th Street					100	20712			U.S		m voomi.
FUN	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	IMED NO	13, 1	WAS DECE	ENDENT OF	HISPANIC C	ORIGIN? (Specify Yeuerto Ricen, etc.)		14. RACE	- American Indian, White, atc.
BY	3 Widowed 4 Divorced	IF YES, OIVE WA	R OR DATES				2 X NO		water the		Specify	
ED	16. DECEDENT'S EDUC (Specify only highest grade of		/G	ECEDENT'S	work done o	CCUPATIO	N st of working	-	16b. KIND OF BU	ISINESS/IN	DUSTRY	
), E	Elementary/Secondary (0-12)	College (1-4 or 5+)	) Hite.	. Do NOT us	se retired.)			7 1.				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		FOT	eman	Pnot	ogra:	aphic				eparti	nent
BE C												
10 B	19a. INFORMANT'S NAME (Type/Print)								Number, City or Tox			
-	Catherine B. Lave	ZZO	1					vie,	Maryland			
	1 ☑ Surial 2 ☐ Cremation 3 ☐ Remo	wal from State	20b. PLACE A cematery, cre Mt. O	AND DATE OF STATE OF	of DISPOSI ther place)	ITION/Nan	ne of	05/25			ton,	
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	//	11000	22,1	NAME AN	D ADDRESS		Sons Fu	IIIIIB		7.
	1 Ponsta	20	Mas	· L	47	ancı 139 F	.s Gas ≀altiπ	sch's	Sons Fu	nera.	L Home	e, P.A. , MD 20781
	23. PART I. Enter the diseases, or co shock, or heart fallure. L	omplications that	coused the de	eth. Do r	not enter	the mod	da of dying	g, such e	cardiac or reap	iratory ar	reat,	Approximata
	IMMEDIATE CAUSE (Finel											Interval Between Onset and Death
	disease or condition resulting in death)	MET	OR AS A CONSE	C	CAR	CIN	OMA	01	= LUNT	9		3 mark
z	<b>.</b> .	DOE 10 ft	UH AS A CONGE	DUENCE OF	F):							
TIO	Sequentially list conditions, if any, leading to immediate	DUE TO (	OR AS A CONSEC	DUENCE OF	F):							
FICA	CAUSE (Disease or Injury	DUE TO (	OR AS A CONSEC	OTTENCE OF	<b>D</b> ,							
ERTIFICATION	that initiated events reaulting in death) LAST	200 10 11	JR AS A CONGLA	JUENCE OF	.):							
O	PART II. Other algnificant conditions	contributing to c	death but not i	itina	In the un	deduing	anna alu	on In Davi			Lance	
EDICAL	777	Continuency to a	POUL POL TIOL .	esunny .	III the un-	Certying	Cause give	/en in rai:	PERFO	RMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
MED									1 TYES	NO	-   '	OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAL				NO 🗆	UNCE	RTAIN [				
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEAT	TH (Check o							
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 I	NJURY	DOA 28b. TIM	4 🗆 Nurs		_/_		Other (Specify)	IN HIRTY OC	CHEED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day	r, Year)		IURY M	WOR			2. DESCRIBE HOTE	MJUN1 JU	CUMED	
8	3 Suicide 8 Could not be determined	26a. PLACE OF building, e	INJURY — At ho	me, ferm, s	street, tacto	ory, office		281	I. LOCATION (Street City or Town, State	and Numbe	r or Aural Ao	ute Number,
PLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of n	ny knowledge, de	ath occurre	ed at the ti	ime, data s	and place, as	nd due to ti	he cause(s) and me	nner as etc	ted.	
COMPL												and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	244					29c. LICENS	SE NUMBER		29d. DAT		Month, Day, Year)

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BRENTWOOD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD.

32. REGISTRAR'S SIGNATURE

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SANKARAN

MAY 3 0 1995

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MD

Pages 1, 2, 3 should

permit.

burial-transit

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

J. BERGER #205,

1995

31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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The law	cate has t	state Dept	item 23
YSICIAN	s certifi	In the	d, or
ING PH	After this	death wil	marke
ATTEN	CTOR	s affer	28 ls
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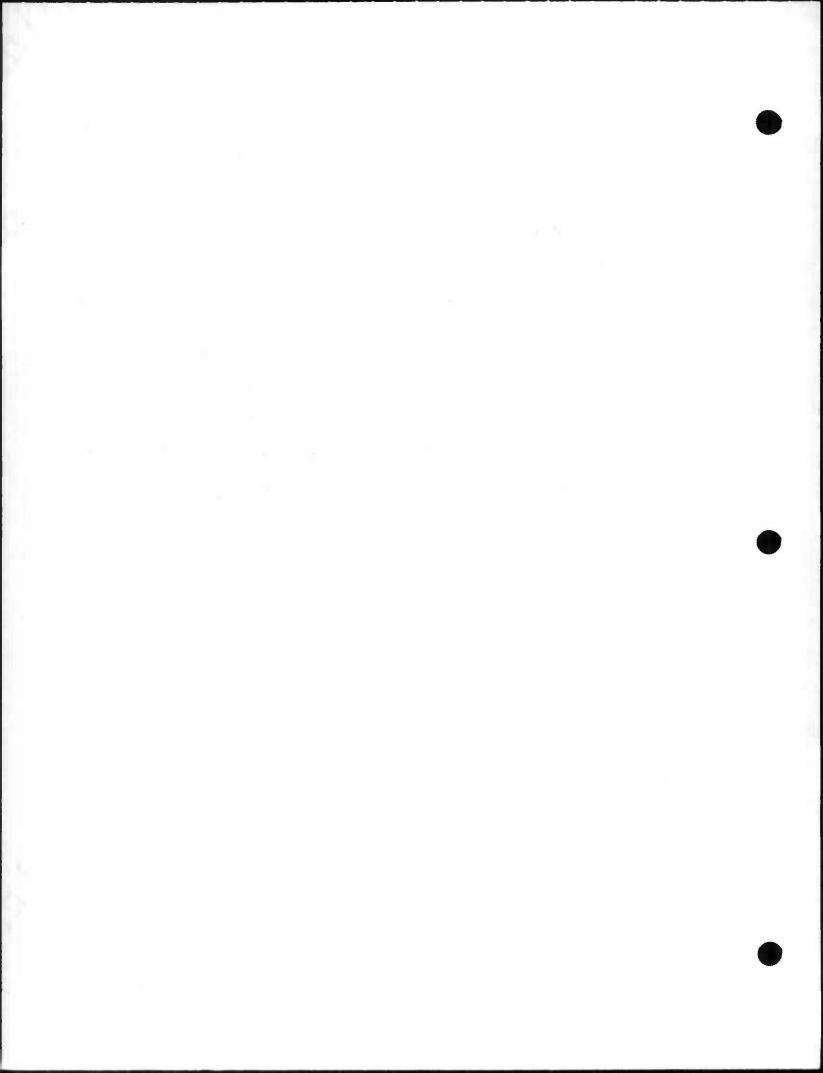
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF OEATN STEPHEN LOOP 995 MAY 4:60 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year, 8. BIRTNPLACE (State or Fore) DAYS HOURS 1 (XM 2 | F 202-16-0963 68 Jan. Pennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF CEATN 2207 Iverson Street PRINCE GEORGE'S Temple Hills 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Temple Hills 1 YES 2 1 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2207 Iverson Street 20748 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XXYES 2 NO FYES, GIVE WIR OR DATES RETIRED APRIL 1967 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pu 1 YES 2 X NO Specify: 1 Never Married 2 Married 3 💢 Widowed 4 🗌 Divorced Specify: White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 10th U.S. Navv Military 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) George Loop Mary Godic 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mark S. Loop 8958 Centerway Rd. Gaithersburg, Md. 20g, METNOD OF DISPOSITION
1 X Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Arlington Nat'l. cemetery 6-7-95 Arlington, Virginia Donation 6 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home 21 SIGNATURE D 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death disease or condition MYOCARDIAL INFARCTION resulting in death) minules OUE TO (OR AS A CONSEQUENCE OF) ALCOHOLISM years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 7 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 □ tnpetlent 2 □ ER/Outpetlent 3 □ DOA EXAMINER? OTHER: 4 ☐ Nursing Nome 5 🎇 Rasidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d DESCRIBE NOW INJURY OCCUPED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide determined 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Beryen MD ► May 29, 1995 DZ5925 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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32, REGISTRAR'S SIGNATURE diwillow Kardall

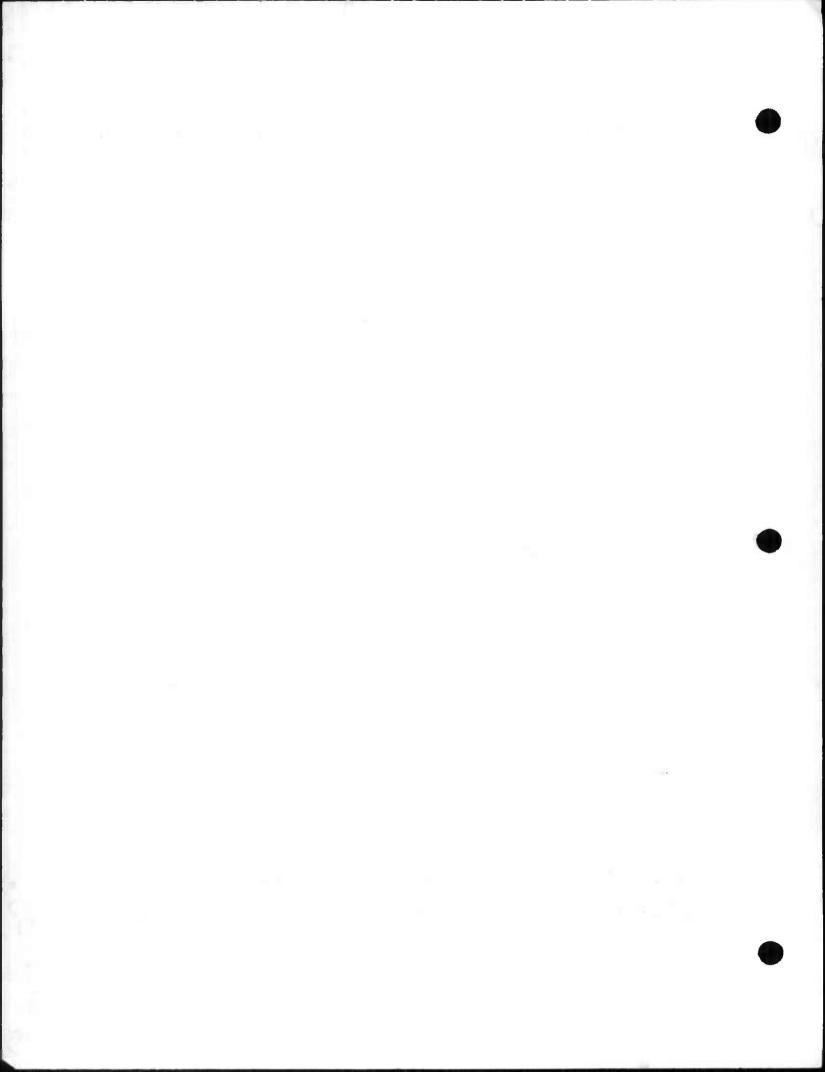
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		permit. Pages 1, 2, 3 should	
SALIMONE, MANICAND SIZIS-0020	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	CONDUCTOR IN TAX AND TAX AND
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RAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH		HYGIENE REG. NO.
S NAME (First, Middle, Last)	1/2	2, DATE OF	DEATH

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPA CERTII	RTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Lat?	more	VILLES DAY 99	SEAR 3. TIME OF DEATH			
		SEX 6. AGE (In yrs. last birthdey, YRS.	MONTHS DAYS HOURS MIN.	Oct. 27,1924				
CTOR			9b. CITY, TOWN OR LOCATION OF Cheverly		nce George's			
DIRE	Md Prince		ry, town or Location enarden		10d. INSIDE CITY LIMITS? 1 YES 2 1 NO			
VERAL	W /9/3 Grant Driv	e	10f. ZIP CODE 207		S.A.			
BY FUN	3 Widowed 4 Divorced D	WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES OC. 1957— June 197	If yes, specify Cuban, Mex		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
LETED	(Specify only highest grade com	(Give kind of lottege (1-4 or 5 +)		16b. KIND OF BUSINESS/ING	DUSTRY			
once. COMPL	12th  17. FATHER'S NAME (First, Middle, Last)	CIVII	Service	Governme  NAME (First, Middle, Meiden Surneme)	nt			
# O	H			o Smith				
2 0	19a INFORMANT'S NAME (Type/Print)	19b. MAILIN		al Route Number, City or Town, State, Zig	n Code)			
10 10	Edith Latimore			enarden, Md.				
2	204-METHOD OF DISPOSITION 1 D Buriel 2 Cremetion 3 Removal	20b. PLACE AND DATE	OF DISPOSITION (Name of	DATE 20c. LOCATION -	City or Town, State			
Hust	4 Donation 5 Other (Specify)	Arlingto	on National Co	emJunl Arling	ton, Va.			
ехатіпет	21. SIGNATURE OF FUNERAL SERVICE LICENS		22. NAME AND ADDRESS OF	racility ns Funeral Ho	mo			
еха	Samlelly Ch	Busca Tonic			wer, Md. 2078			
event, the medical	23. PART I. Enter the diseases, or companhock, or heart feilure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	only one cause on each line.	ling pelerone		Approximate Interval Between Onset and Death			
ry, or other traumatic event, the CERTIFICATION	Sequentially list conditions, if any, lacding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE O						
shows any Injury, : MEDICAL CE	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO							
S   S	DID TOBACCO USE CONTRIBU			IN D				
r Item		OSPITAL:	TH (Check only one) OTHER:					
PHYS	27. MANNER OF DEATH  1 An Autural 5 Pending	Inpetient 2 ER/Outpetient 3 DOA  28a. DATE OF INJURY (Month, Day, Year)  28b. TII	4 Nursing Home 5 Residence  ME OF 28c, INJURY AT WORK?  M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCC	CUREO			
28 Is TED	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY — At home, farm, building, etc. (Specify)	street, tactory, office	281. LOCATION (Street and Number City or Town, State)	or Rural Route Number,			
IMPORTANT: If Item O BE COMPLE		: To the best of my knowledge, death occur in the basis of examination and/or investigati						
TO BE (	299. SIGNATURE AND TITLE OF CRIMINERS  SIGNATURE AND ADDRESS OF PERSON WHO CO	diffus MD	20 LICENSE N	UMBER 294 DAT	E SIGNED (Month, Day, Year) 426, 1995			
	31. DATE FILED (Month, Day, Year) MAY 3 0 1995	22. REGISTRATE SUNATURE STUDIES REVOLU	ayburn Ch C	Dapo Mo	0748			



June

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FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

113-20-2347

1. DECEDENT'S NAME (First, Middle, Last)

Cvnthia

5. SEX

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3 shou	- 1	9e. FACILITY NAME (If not institution, give etreet and number)				9b. CITY, TOWN OR LOCATION OF DEATH 9c. CO				TY OF DEATH
2,3	DIRECTOR	Annapolis Nursing	& Rehab C	enter		Annapolis			Anr	ne Aru
	딦	RESIDENCE OF DECEDENT  100. STATE  10b. COUN	TY	100	CITY, TO					
physician. burlat-transit permit. Pages 1,	E		nne Arundel	100.			polis			10d.
ije.		10e. STREET AND NUMBER	inc Aranaci			711110	10f. ZIP CODE		Table CITIZ	I EN OF WHAT
is M	12	3133 Anchorage	Drive				21403			ited S
cian. I-tran	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARMED	Т	13 WMS	DECENDENT OF HISPA			II LEU S
g at	D BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YE	S 2 NO		If yes	, specify Cuben, Mexic YES 2 XNO Speci	en, Puerto Rici		Black, Wh Specify:
use as	l iii l	15. GECEDENT'S ED (Specify only highest grad		16a. DECEDER (Give kind	d of work d	lone during	ATION most of working	16b. KI	ND OF BUSINESS/INDU	STRY
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by the hospit be detached at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last)		A	dmini	istra			State Depa	artmer
be de	- 1	Daniel Eldridge							fle, Malden Surname)	
5 should notified	B	19a. INFORMANT'S NAME (Type/Print)		19h MAII	INC ADD	DECC /Com		ra Kef	Tier City or Town, State, Zip (	
5 should notified	입	William D. Lync	h						Texas 787	
ay be		20e. METHOD OF DISPOSITION	2	0b. PLACE AND DA				OATE	20c. LOCATION — C	
leath. Page 6 may be funeral director, page xaminer must be		1 Donation 5 Other (Specify)	moval from State	emetery, crematory	or other pla	acel	natory 6/18	1	Brentwoo	
Pag al dir		TO MONATURE OF FUNERAL SERVICE L	ICENSEE /	yes Line			E AND ADDRESS OF FA	ICII ITY		
death. Pag tuneral dii I. examiner		Horas Od V	To You			1 47	Dules of		nn M. Tayl	
ours after of In by the or removal.	$\vdash$	23. PART I. Enter the diseases, or	complications that cause	ad the death f	Do not as	147	Duke of	Glouce	ster St. A	napoi
IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an IRECTOR: After this certificate has been signed by the attending physician and completely fill thus after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation in 28 is marked, or Item 23 shows any injury, or other traumatic event, the	D BY PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions.  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 Natural 5 Pending Investigation and Conditions of the conditions	OUE TO (OR AS  OUE TO (OR AS  OUE TO (OR AS  d	S A CONSEQUENCE  S A CO	YES DEATH (Ch	NO NO NO NO NO NO NO NO NO NO NO NO NO N	UNCERTAL  TOTAL   6 Other (S) 28d. DESCRI	BE NOW INJURY OCCU		
	COMPLETED	4 Nomicide determined  29e. CERTIFIER (Check only	BICIAN: To the best of my kno	owledge, death oc	curred at t	he time, c	late end place, end due	City or 1	own, Stete) e) end manner as stated	1.
TO THE HOSPITAL OF TO THE FUNERAL D DE FIED WITHIN 72 ho	8	- Andrewson - Andr	ER: On the quests of egaphines	non end/or investig	etion, in r	ny opinio	n, death occured at the	time, date and	I place, end due to the	ceuse(e) end
표분	H	296 SIGNATURE AND TITLE OF CENTIFIE	1	1	_		29c. LICENSE NU			SIQNED (Mont
2633	<u>و</u> ا	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAMPE	4			D0519	92	Ju	ine 7,
						Λ	nonalia M	D 0140	1 (410 000	7570
		Richard I. Hochn 31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG		Ave	. An	napons, M	D 2140	71 (410-268	-1516
	- 1	1	II-GIGINAN 3 SIG	HINT OFFE						

This Davideor Randall

JUN 08 1995

CERTIFICATE OF DEATH

IF UNDER 1 YEAR | IF UNDER 24 HRS.

DAYS

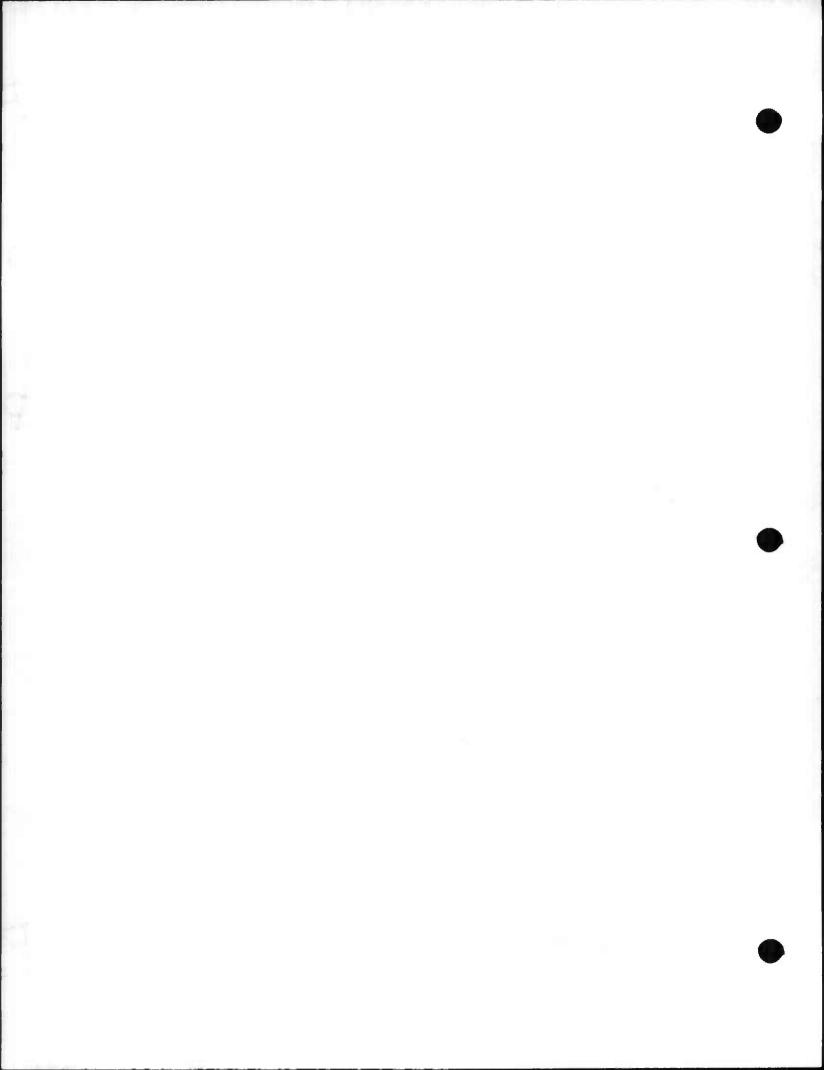
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6. AGE (In yrs. lest birthday)

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH MONTH 3. TIME OF DEATN YEAR 1995 2:35P 7. DATE OF BIRTIN (Month, Day, Year) Feb 15 1911 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY 1 YES 2X NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. White F BUSINESS/INDUSTRY ate Department iden Surname) r Town, State, Zip Code) exas 78703 c. LOCATION - City or Town, State Brentwood, Maryland M. Taylor Funeral Home er St. Annapolis, MD Approximata Interval Between respiratory arrest, Onset and Death S AN AUTOPSY RFORMEO? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? S 2 M NO 1 YES 2 NO OW INJURY OCCURED reet end Number or Flural Route Number, tete) manner as stated. e, end due to the ceuse(e) end manner ee stated. 29d. DATE SIQNED (Month, Day, Year)

June 7, 1995



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 995 **GLEN** SR. LAVIN JUNE 6:35 A SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Apra 24, 19 HOURS 1 M 2 F 65 YRS. 217-28-9500 Maryland permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a, STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Allegany Frostburg Maryland 1 TYES 2 NO NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 21532 19318 Lower Consol Road, N.W. use as the burial-transit U.S.A. Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— H was exactly Cuben. Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerio Ri
1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify 1948 White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16h KIND OF BUSINESS/INDUSTRY (Sn (Give kind of work done life, Do NOT use retired.) College (1-4 or 5+) Operator 1 County Roads Dept. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Winona Rosenberger Leo Lavin notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
629 Leiper St., Cumberland, Md. 21502 2 Belinda Lavin pe 26 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, Blocher Cemetery 4 Donation 5 Other (Specify) 6/4 Garrett Co., Md. 22. NAME AND ADDRESS OF FACILITY 57 Frost Ave. examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEF hours after death. Durst Funeral Home, Frostburg, Md. 21532 and completely filled in by the the medical 23. PAST i. Enter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. intarval Batween cremation, or IMMEDIATE CAUSE (Fine) Onset and Death disease or condition ACUT CEROBOOVASCULAD ACCIDENT 20 min within resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) executed prior to burial, METASTATIO 2 mount pre CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF): if any, leading to immediate been signed by the attending physician it, of Health and Mental Hygiene prior to certificate be cause. Enter UNDERLYING CAUSE (Disease or injury ARCINOMA other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 PART II. Other aignificant conditions contributing to daeth but not resulting in the underlying cause given in Part i. 24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? MEDICAL any 1 TES 2 100 OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: has be W. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem this certificate h HOSPITAL:
112 Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 2 WO 10 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. 1 Metural 5 Pending 1 YES 2 NO BY After t 2 Accident OR ATTENDING 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number City or Town, State) 09 COMPLETED DIRECTOR: A 6 Could not be 4 Homicide 28 determined Item Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL (
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If It 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND JUTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 20/12 JUNE WBENT D31875 95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WELIK, ROBERT, M.D. 902 SETON DRIVE CUMBERLAND, MD 21502 32. REGISTRAND BON

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

A SE	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buna-transit permit. Page be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to bunal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	ATTENDING PHYSICIA	ECTOR. After this certil 's after death with the	n 28 is marked, or

CERTIFICATION

MEDICAL

PHYSICIAN:

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95 18578 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY 1995 ELSIE VIOLA LEWIS 28 1:37 P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Yea B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS 216-22-5420 69 HOURS 1 M 2 XF YRS Aug. WV 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital Cumberland Allegany RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY WV Hampshire Springfield t YES 2 XNO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 264 26763 US 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE --- American Indian, Black, White, stc. FORCES? 1 YES 2 NO 1 Never Married 2 Married Specify: white BY 1 YES 27 NO Specify. 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) NA Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George H. Cox BE Bertie Horn 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Peggy S. Steward PO Box 264, Springfield, WV 26763 20a, METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION --- City or Town, State cemetery, cremetory or other place)
Wesley Chapel Cemetery May 31 Donation 5 C Other (Specify) 995 Points, WV 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc. 230 E. Main St., Romney, WV 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haert failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition AS A CONSEQUENCE OF: resulting in death) CATE MY OCARDIAL ENFARCTION Sequentially ilst conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury that initiated events reaulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO AMYOTROPHIC LATERAL SCIEROSIS COMPLETION OF CAUSE 1 | YES 2 | 10 1 TES 2 110 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN otin25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

1 TYES 2 12 NO	1 Inpetient 2 ER/Outpetient 3	DOA 4 Nur	R: rsing Home 5 🗆 Residence	6 ☐ Other (Specify)
27. MANNER, OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?  1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At horr building, atc. (Specify)	ne, farm, street, fec	tory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

a. CERTIFIER	4 M PROTIFUING BUYONG IN T. II.
(Check only	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
one)	
/	2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.
	and the causels) and mariner as stated.

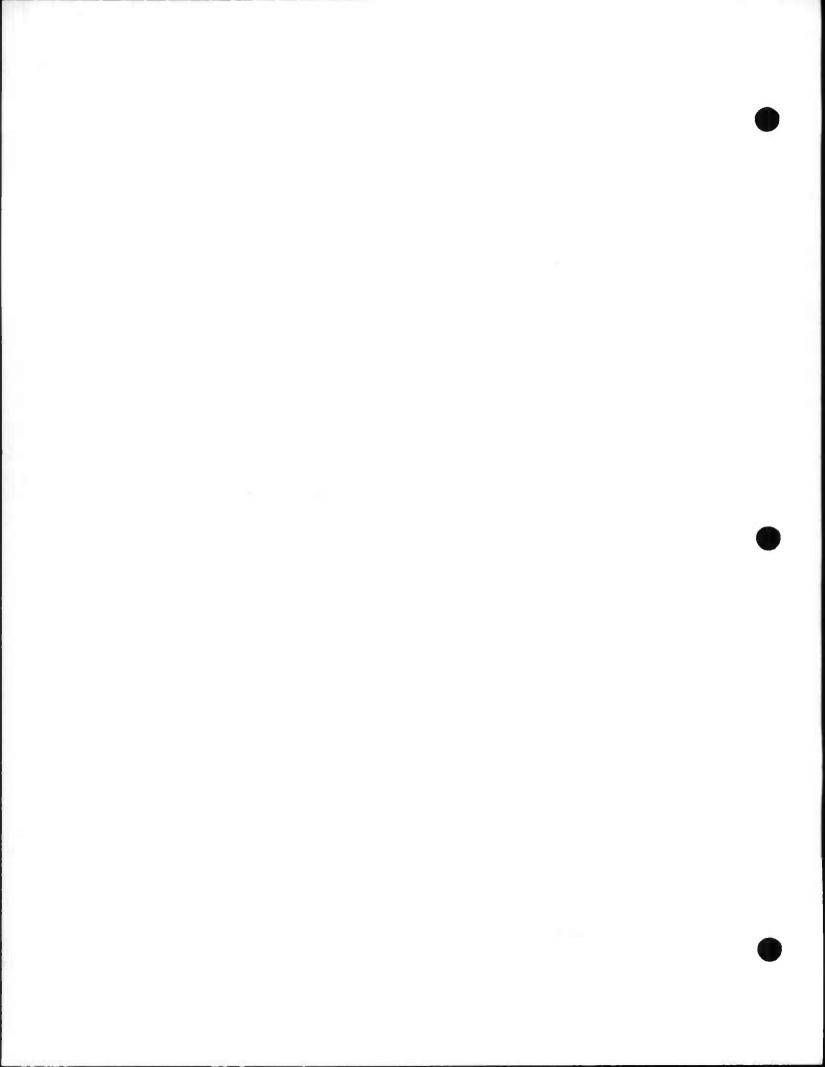
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, War) D 23334 28/95 MAY

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DINESH SHAH M.D., P.O. BOX 131, PINTO, MD 21556

31. DATE FILED (Month, Day, Year)

132. REGISTRAR'S SIGNADIRE



REG. NO

<b>BALTIMORE, MARYLAND</b>	1. The four enemies that death partitions he executed within mount offer death Done & row he cabined he the house
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ITAL RECORDS, P.O. BOX 68760	ertificate he executed with
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FOR STATE REGISTRAR 1 DECEDENT'S NAME (First Middle Leat) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Edna Marie May 1995 Lange 5:15A 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) S SEY 6. AGE (In yrs. last birthday) IF UNDER I YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig 84 DAYS Maryland 1 [] M 2 [XF 219-03-9814 March 4 911 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Allegany Lonaconing Egle Nursing Home. Inc Pages 1. Mary Land Allegany JOG CITY, TOWN OR LOCATION LONGCONING 10d. INSIDE CITY LIMITS? XX YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 45 Douglas Avenue use as the burial-transit 21539 USA attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 021215-0020 1 Never Married 2 Married YES 2 NO Specify: BY 3 ₩ Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INOUSTRY (Give kind of work done during life. Do NOT use retired.)
Homenaker oital or detached for entary/Secondary (0-12) College (1-4 or 5+) Home 6 0 once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surrame)
Susan Marie Clark MacMillan 5 8 notified at BE 5 should 194. INFORMANT'S NAME (Type/Print)
Kimberly A. Fazenbaker 196 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17211 Old County Road, Frostburg, Md. 21532 page pe 20a. METHOD OF DISPOSITION
1 ♥ Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must funeral director, Donation 5 Other (Specify) Park unset Mem. May 30, 1995 Cumberland, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home the lavo Lonaconing Md. 21539 medicai 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, filled in by shock, or heart fallure. List only one cause on each line. Interval Between 6 Onset and Death IMMEDIATE CAUSE (Finsi and completely fille burial, cremation, the ntractable Conges disesse or condition\_ resulting in desth) or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A COMBEOUENCE OF): lenosclerosi HAUS CERTIFICATION Sequentially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury the attending phy Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Pulmonary huchue. 1 TYES 2 NO 1 YES 2 NO been f. of PHYSICIAN: has be Dept. 8 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem this certificate h **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 12 N ng Home 5 - Residence 8 - Other (Specify) OR ATTENDING PHYSICIAN 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, Netural 5 Pending investigation 1 YES 2 NO BY After 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 🔲 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 ls 8 Could not be DIRECTOR: / COMPLETED 4 Homicide item 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL I within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II mination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of axa 296. SIGNATURS AND TITLE OF CENTRIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D07004 26 1995 2 May 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Leslie R Miles 10 St. Peters Place, Lonaconing, Jr. M.D MD 21539 31. DATE FILED (Month, Day, Year) - 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 

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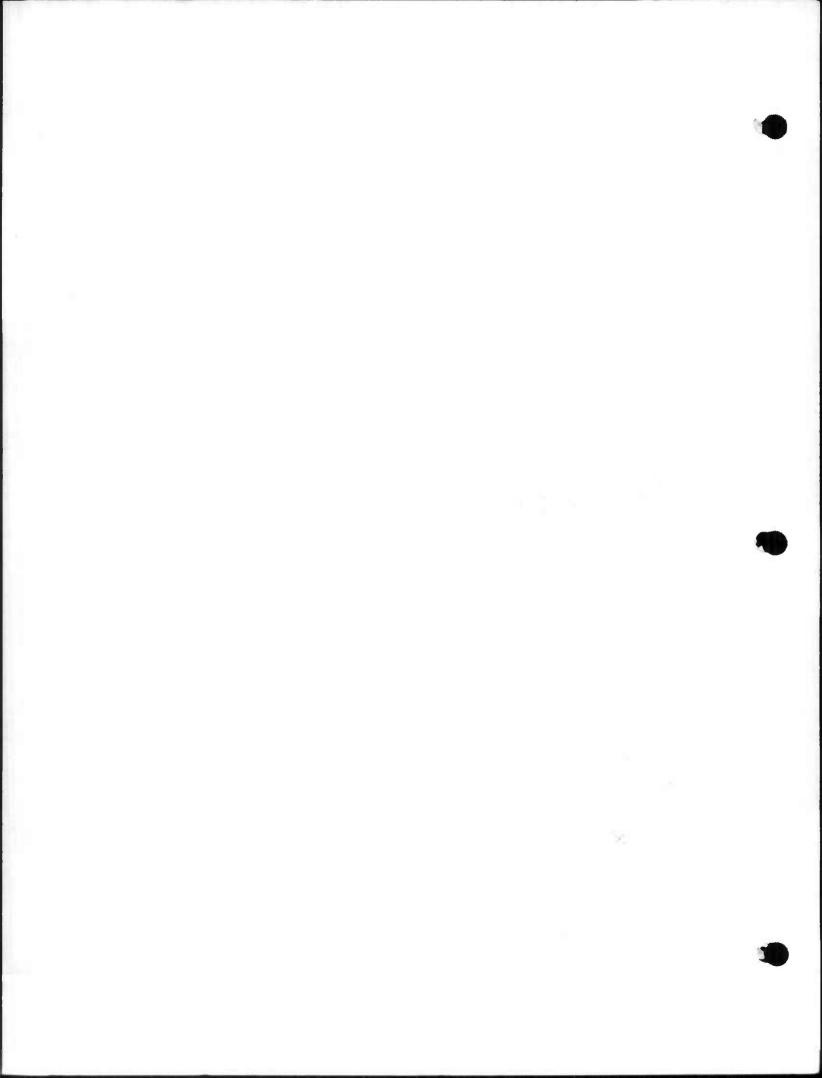
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12-mounts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	MYRON SAMUEL	LANDIS				MAY 26	1995	3:00 Pm M
	4. SOCIAL SECURITY NUMBER	1 1	(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	214-05-7536		91 YRS.	MONTHS DAYS	HOURS MIN.	OCT 18 19		MARYLAND
_	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
6	DELVIN MANOR NURS	ING HOME		CUMBE	RLAND		ALLE	GANY
Di l	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	1	10c, CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR	MARYLAND ALI	EGANY	CI	MBERLANI	)			LIMITS? X ☑ YES 2 ☐ NO
1	10o. STREET AND NUMBER				, ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	815 BEDFORD STR	KEET			21502		U.S	.A.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES				NIC ORIGIN? (Specify Ye	s or No 14	. RACE — American Indian,
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			NO Special	nn, Puerlo Rican, etc.) ly:		Specify: WHITE
				- 1				
E	15. OECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of v	USUAL OCCUPATION FOR YORK done during more retired.)	ON st of working	16b. KIND OF BU	SINESS/INDUS	TRY
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)	1,000					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		TOWNER/OF	ERATOR		YPEWRITER  ME (First, Middle, Maiden		ALES/SERVICE
	SAMUEL ETCHMAN I	ANDIC					ourname)	
) BE	19e. INFORMANT'S NAME (Type/Print)	ANDIS	19b. MAILING	ADDRESS (Street a		IE BOSTON  Route Number, City or Tox	vn, State, Zip Co	c(e)
2	JOHN PAUL LANDIS		1582 (	OMANCHE	ROAD A	RNOLD MARY	CIGAT	21012
	20a. METHOD OF DISPOSITION 1 ☐ Burlet Ž\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	201	PLACEANDDATEC	EDISPOSITION /No	me of	DATE 200 LC	CATION - CIN	or Town State
	4 Donation 5 Other (Specify)	CI	JMBERLAND	CREMAT(	ORY MAY	27 1995 CU	MBERLA	ND MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSPT CIL		22. NAME AF	ID ADDRESS OF FA	FUNERAL H		
	hale d.	LOINIX				TREET CUMB		MADVIAND
	23. PART I. Enter the diseases, or c	omplications that cause	d the death. Do n	ot enter the mo	de of dying, suc	h as cardisc or resp	iratory srrest	, Approximate
	shock, or heart failure. I	List only one cause on e	ech line.	<b>-</b>	0 0	$\cap \cap \cap$	10	Interval Between Onset and Death
	disease or condition resulting in death)	. Derul	e 1 le	men	L.	IL al	7he	- Knie
	i country in country	DUE TO (OR AS	A CONSEQUENCE OF		1	0.	1	13,680
Z	Sequentially list conditions,	b				XIQ!	$\bigcirc$	1100
Ĕ	If sny, lesding to immediate cause. Enter UNDERLYING	DUE TO (OR AS /	A CONSEQUENCE OF	j):		0		
걸	CAUSE (Disesse or Injury	DUE TO (OR AS	A CONSEQUENCE OF	7.				
CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (ON AS A	- CONSEQUENCE OF	Ţ.				
CEI		1					-	
A	PART if. Other significant conditions	s contributing to deeth b	out not resulting I	n the underlying	csuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
음						1 🗆 YES	NO	COMPLETION OF CAUSE OF DEATH?
ME						_		1 TES 2 NO
PHYSICIAN: MEDIC								
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (CA	eck only one)		
YS	1 TYES 2 NO	1 - Inpatient 2 - ER/Out		Nursing Hom	e 5 🗌 Residenca	6 Other (Specify)		
	27. MANNER OF DEATH  Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b, TIMI INJ	URY WO	RK7	26d. DESCRIBE HOW	INJURY OCCUR	ED
BY	2 Accident Investigation	200 DI ACE OF MILLION			ES 2 NO			
9	3 Suicide 6 Could not be detarmined	28s. PLACE OF INJURY building, etc. (Spe	cify)	treet, factory, office		281. LOCATION (Street City or Town, State)	and Number or I	Rurel Route Number,
Ш	29e, CERTIFIER							
COMPLETED	(Check only	CIAN: To the best of my know						
8			and or overtigation	, m my opinion, d	each occured at the	time, state and place, as		evee(s) and manner as stated.
BE	290. SIGNATIONE AND TITLE OF CERTIFIER		$\neg \land \land$		29c. LICENSE NUI	WBER	294. DATE S	GNED (Morrin, Day Mars)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) G	Print)	1110	111	- 2	90/4/
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	DR GUY FISCUS M	32, REGISTRAN & SIGN	ATURE BUILL	DING MEN	OKTAL A	VE CUMBERL	AND MAI	KYLAND 21502
l	MILL 9 6 1939	/						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	1 - STATE REGISTRAR	STATE OF !	MARYLAND /	DEPAR	RTMEN	T OF H	IEALTH DE AT	AND I	MENTAL				
	1. DECEDENT'S NAME (First, Middle, Last)		- 0.		ICAI	LOI	DEA	<u> </u>	La DATE	REG. NO			A 7000 07 07 07
		- 11-			1 3				MONTH	De		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	setta				215	1		m	My 2	51	995	
		5. SEX	6. AGE (In yra. las		IF UNDE	DAYS	IF UNDER	24 HRS.		DE BIRTH		8. BIRTI	IPLACE (State or Foreign
	206-18-3824	1 □ M 2 🔯 F	68	YRS.		-	noons	anita,		3, 19	926		nsylvania
	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CIT	Y, TOWN C	OR LOCATIO	ON OF DE				INTY OF D	
1 8	Shady Grove Adve	ntist Ho	spital			Roc	kvil:	16			м	onta	omerv
DIRECTOR	RESIDENCE OF DECEDENT					1100					1.1	onleg	omery
1 12	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	HON						10d. INSIDE CITY LIMITS?
ā	Maryland Mon	tgomery			Rock	vill	e						1 X YES 2 NO
1	10e. STREET AND NUMBER					101	. ZIP CODE	E	_		10a, CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	1713 Tweed Stre	et					208	5.1					States
3	11. MARITAL STATUS		T EVER IN U.S. AR	MEO	13	WAS DEC			NIC OBIGIN	(Specify Yes			
	1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	YES 24	NO	10.	If yes, sp	ecify Cuba	n, Mexica	n, Puerto R	ican, etc.)	OF 140-	Blac	E — American Indian, k, Whita, etc.
8 ∠	3 🔀 Widowed 4 🗌 Divorced	IF YES, OIVE V	AR OR DATES			1 TYES	2 X NO	Specify	y:			Spec	
	15. DECEDENT'S FOU	CATION	140 00	CEDENT'S	HEHAL	2001/047/0	241		-				White
	(Specify only highest grade	completed)	(G	live kind of a	work done	during mo	st of workin	g	160.	KIND OF BUS	SINESS/INI	DUSTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5	• )							0			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		l n	lomem	aker					Own			
							18. MOTH	HER'S NA	ME (First, M	liddle, Maiden	Surname)		
H	John J. Zimmerm	an							Doubt				
2	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	nd Number	or Rural I	Route Numb	er, City or Tow	n, State, Zij	p Code)	
	Kimberlee A. Pot	ter	1	8810	Pur	ple i	Mart:	in L	ane,	Gaith	ersb	urg,	MD 20879
	20a. METHOD OF DISPOSITION 1 Buriel 2-A Cremetton 3 Hem		20b. PLACE cometery, cre								CATION -		
	4 Donation 5 Other (Specify)	ovar from state	Mont g	omer.	ther place. V Cr	emat	ay 2 oriu	m, İ	nc.	Bet	hesd	a. Ma	aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	77	0831									
	N. K. ber Or	m, m.	11/1/1/	1000	R	ockv	ille	, In	c. 3	00 We	st M	ontg	/ omery 50-2805
$\vdash$	Darbara Jo	11/crija	eego ru	CA DAK	-U A	venu	e, Ro	ockv	ille,	Mary	land	208	50-2805
	23. PART I. Enter the diseases, or a shock, or heart failure.	List only one cau	caused the de	ath. Do r	not ente	r the mo	de of dyl	ng, suc	h aa cardi	ac or reapi	ratory ar	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final												Onset and Death
	disease or condition resulting in death)	. Metasta	atic Non	Sma.	11 C	ell :	Lung	Can	cer				2 months
			(OR AS A CONSE										
z	was a stand assessment	b.											
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	DUENCE OF	F):								
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	C.											!
Ē	that initiated events	DUE TO	(OR AS A CONSE	DUENCE OF	F):								
E	resulting in death) LAST	d.											
5													
¥	PART II. Other algnificant condition	s contributing to	death but not r	reaulting	in the u	nderlying	ceuse g	lven in	Part I.	24s. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL										1 TYES 2			COMPLETION OF CAUSE OF DEATH?
¥											24-		1 TES 2X NO
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	SIT	NO V	LUNC	ERTAIN	un l				· [] ico zaj no
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			E OF OEAT			0.10	LICITAN	, 121				
10%	EXAMINER?	HOSPITAL:	ER/Outnotlant 3	□ DOA	OTHE			-/	a 🗆 au	40			
ΙžΙ	27. MANNER OF OEATH	26e. DATE OF		28b. TIM		28c. (NJI		eldence	8 Other	(Specify)	N III III OO	CURED	
	1 🔀 Netural 5 🗌 Pending	(Month, D		INJ	URY	WO	RK?	ا مر	200. 0230	NIBE NOW II	NONY OC	CORED	
B	2 Accident Investigation	26- DI ACE O	E IN HIPV	1				J NO					
	3 Suicide 6 Could not be 4 Homicide determined	building,	F INJURY — At ho atc. (Specify)	ima, tarm, t	straat, tac	tory, office	•		City o	TION (Street a r Town, State)	ind Number	r or Rural F	Toute Number,
<u>.</u>													
길		CIAN: To the best of											
COMPLETED	one) 2 MEDICAL EXAMINE	R: On the basis of a	xamination and/or	Investigatio	n, In my	opinion, de	eath occur	ed at the	time, deta i	and place, an	d due to th	he cause(s	) and manner as stated.
	29M SIGNATURE AND TITLE OF CERTIFIE	11.				T	29c, LICE	NSE NIIL	(BER		294 DAT	E SIGNED	(Month, Day, Year)
8	Chhulun KI	Hards	rihs	N	w				236	_	▶ A /	1/L W	
2	20 NAME AND ADDRESS OF PERCON WA	O COMBLETED CALL	SE OF OFFICE HERE	M ATD (To-	21.0		<u> </u>	J [	UZK		- 10	1/4	26, 1995

ks, M.D. 14808 Physicians Lane, #212, Rockville, MD

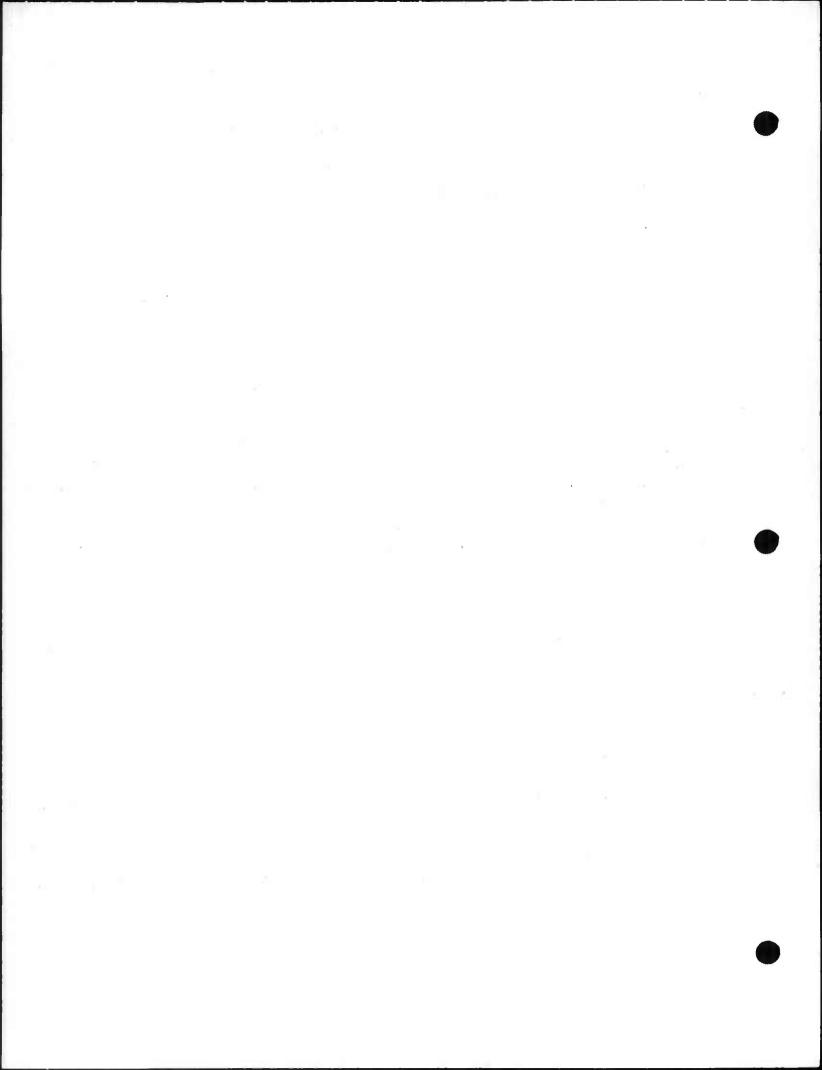
WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

Hendricks,

Carolyn B.

31. DATE FILED (MONTH, Dey, Year)
MAY 30 1995

20850



DHMH-18 Rev 1/80

2. DATE OF DEATH MONTH

FOR STATE REGISTRAR

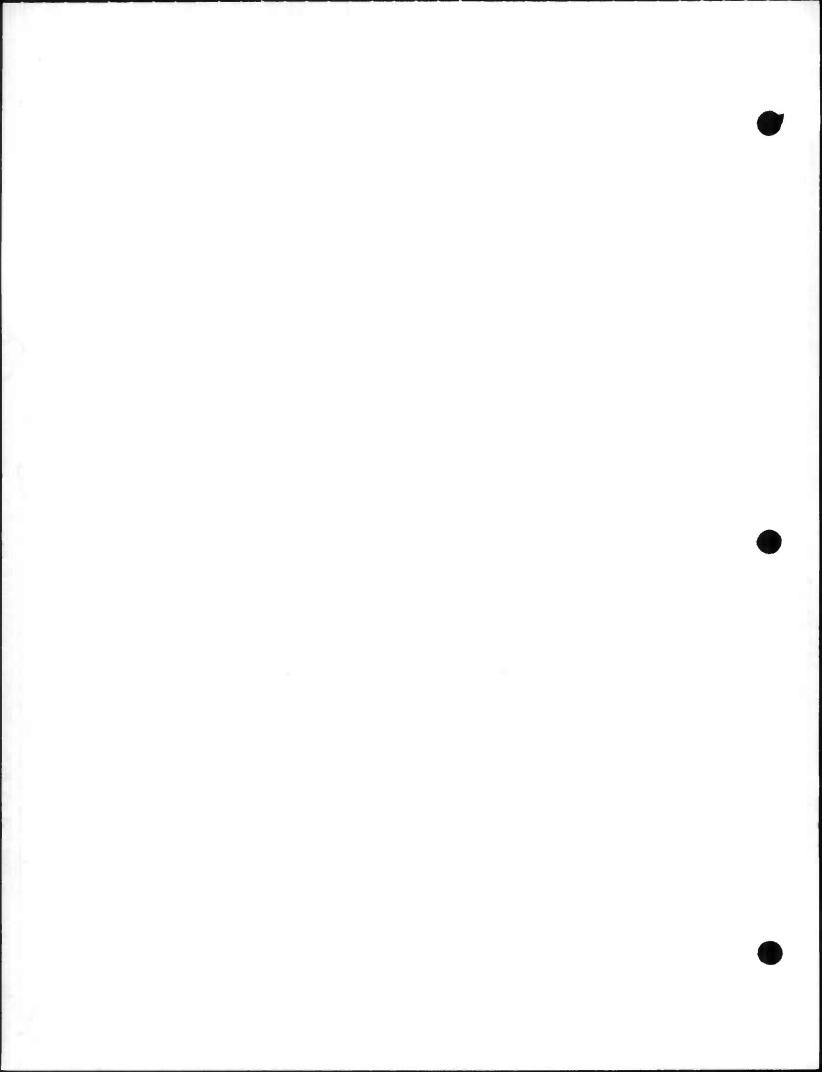
1. DECEDENT'S NAME (First, Middle, Last)

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VITAL RECORDS
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MONTH 2:30 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign June 14, 94 215-44-8525 HOURS 1 M 2 K F YRS 1900 Washington, D.C. permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Maryland Prince George's Hyattsville 1 X YES 2 ND 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 2264 Hannon Street Page 6 may be retained by the hospital or attending physician. 20783 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 N NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 Merried Specify: White BY 3 🖾 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Press Feeder Gov't. Printing Office 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) Louis Lipkin to Rachel Harrison BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rochelle Nezin 2950 Strauss Terrace, Silver Spring, Maryland 20904 9 20a, METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must functil director, Fort Lincoin Cemetery 5/26 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. SKINATURE OF FUNERAL BERVICE LICENSEE medipsi-examiner 22. NAME AND ADDRESS OF PACILITY Hines-Rinaldi Funeral Home hours after death. 11800 New Hampshire Avenue filled in by the fi Silver Spring, Maryland 20904 21 PART I. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Betwee IMMEDIATE CAUSE (Final Onset and Death 器 disease or condition\_ completely resulting in death) traumatic event. al Cha 100 DUE TO JOR AS A CONSEQUE executed burist. CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior in if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician 2 certificate other DUE TO JOH AS A CONSEQUENCE OF that initiated events resulting in death) LAST ö has been signed by the after Dept. of Health and Mertal PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? that shows any 1 TYES 2 TONO requires 1 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) OR ATTENDING PHYSICIAN: The THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate In fled within 72 hours after death with the State HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? marked, 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 3 Suicide COMPLETED 8 Could not be 28 4 Homicide Пеш 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the firme, date end place, end due to the cause(e) end manner as stated. TO THE HOSPITAL TO THE FUNERAL DE FILE WITHIN 72 h 2 MEDICAL EXAMINER: On the beste of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) New 62. REGISTRAR'S SIGNATURE Julia Davidson Rardall 30 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

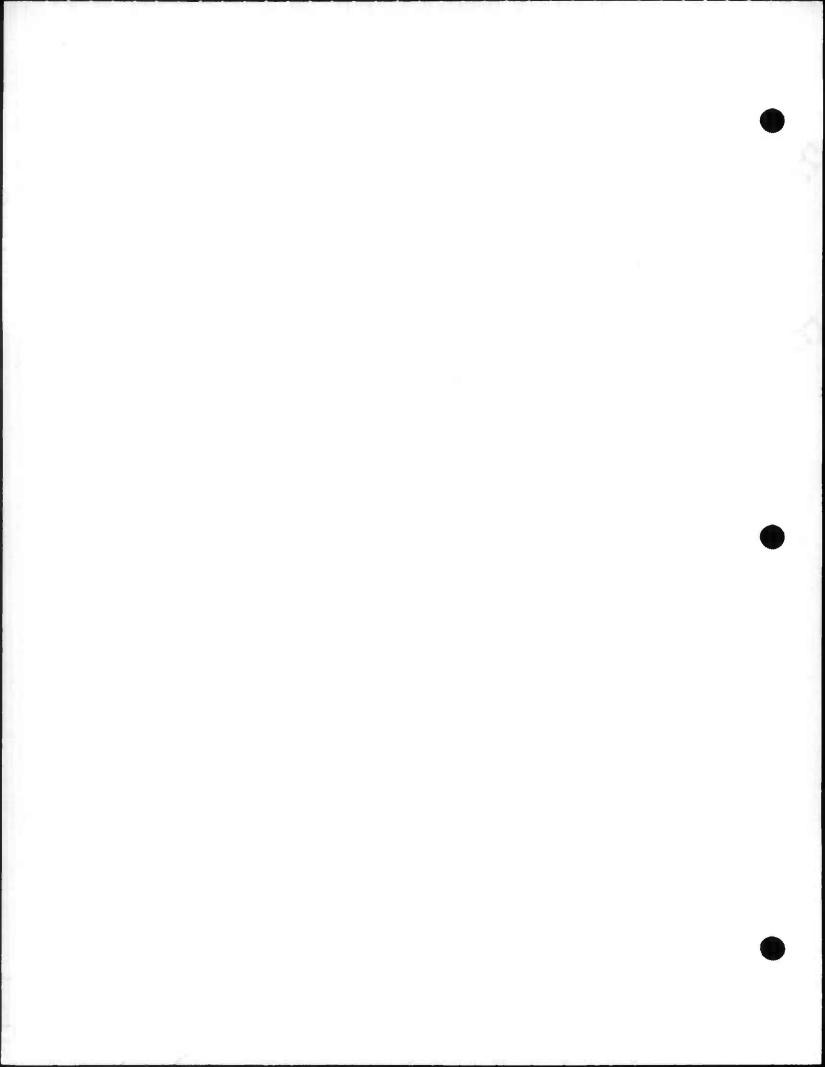
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

						IOATE	- 01	DEAT	**		HEG. NO			
	1. DECEDENT'S NAME (First, DENNIS		ENE	MATH	ECON					2. DATE O	D	AY 100	YEAR	3. TIME OF DEATH
	DENNIS EUGENE MATHE 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les								MAY 27, 1995				3:00 P M	
	214-78-4038 1 XM 2 - F 35 YRS. MONTHS DAYS HOURS							MIN.	(Month,	Day, Year)	1960	Count	PPLACE (State or Foreign ry) ington, D.C.	
_	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY,	TOWN	OR LOCATIO	N OF D				UNTY OF D	
DIRECTOR	6 Colonial					Roc	kvi]	le				Mor	ntgom	ery
EC	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN O	R LOCAT	ION						10d, INSIDE CITY
	Maryland	Mont	gomery		Roc	kvil	le							LIMITS?
Z	10s. STREET AND NUMBER			-			101	. ZIP CODE				10g. Cl	FIZEN OF V	WHAT COUNTRY?
BY FUNERAL	6 Colonial	Court	12. WAS OECEDEN					2085					-	States
F	1 Never Married 2		FORCES? 1	YES 2 X	NO	11	yes, sp	ecity Cuban	, Mexica	NIC ORIGIN? In, Puerto Ric	(Specify Yes an, etc.)	or No-	Black	E — American Indian, k, White, etc.
	3 Widowed 4 X Divo	rced	# 1E3, GIVE #	EN ON DATES	_	'	U YES	2 X NO	Specif	y:			Speci	White
COMPLETED	15. DECI (Specify only	highest grade	CATION completed)	(0	ECEDENT'S	vork done d	CUPATIO	ON ast of working	7	16b. H	IND OF BU	SINESS/IN	DUSTRY	
PLE	Elementary/Secondary (0-	-12)	College (1-4 or 5 a	F)	ecept	,	et			Λ-	imal	Hoer	vi+al	
OM	17. FATHER'S NAME (First, Mi	ddle, Last)		Til.	ссерс	10111.	3 L	18. MOTN	ER'S NA	ME (First, Mic			Trai	
BE C	Fred	Rober	t	Matheso	n,	Sr.		Eth		, , , , , , , , ,	Vio			Stairs
0	19a, INFORMANT'S NAME (7)									Route Number			p Code)	
-	Mary Mathes		ter (Sis			_			, G.	Lenda1		_	769	
	20a. METHOD OF DISPOSITION Burial 2 X Cremation 5 Other	n 3 🗌 Remo	oval from State	20b. PLACE cometery, cre Ches	AND DATE (	of DISPOSI ther place)	TION (Na	me of		DATE			City or To	
	21. SIGNATURE OF PUNERAL		ENGEE /	-   Chesa	apeak	22. N	NAME AN	D ADDRES	S OF FA	CILITY	Belt		rte,	MU
	2 off.	-13.6	061	MO	0827	Raj	pp F	uner	al S	Servic Silve			MD	20910
	28. PART I. Enter the di	seasea, or c	omplications that lat only one ceu	t caused the de	eath. Do r	not enter	the mo	da of dyir	ng, suc	h aa cardia	c or reap	ratory as	reat,	Approximate
	IMMEDIATE CAUSE (Fin		Liet only one ceu	ise on each line	B.									Onset and Death
	disease or condition resulting in death)	<b>+</b> .	Major S	Seizures	(gr	and m	nal)							6 Wks
				(OR AS A CONSE		,.								40 44-
NO.	Sequentially list conditions, If any, leeding to immediate Due to (or as a consequence of):													
CERTIFICATION	cause Enter UNDERLYING Acquired Immune Deficiency Syndrome										21 Mos			
	that initiated events reaulting in death) LAST			(OR AS A CONSE										0.5
EH CEH			HIV ini	fection	(kno	۷n)								25 Mos
AL		PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY FINDINGS PERFORMED?  AMILIABLE PRIOR TO												
MEDICAL	Vomiting,	weight	t loss				_			_	YES 2			COMPLETION OF CAUSE OF DEATH?
	DID TORACCO H	TE CONTE	IDLITE TO CA											1 TES 2 X NO
¥ N	DID TOBACCO US		IBUTE TO CA		E OF DEAT			UNCE	RTAII	1 🗆				
SIC	EXAMINER?		HOSPITAL:			OTHER	:	SV Res	Idence	8 Other (	Onnolfic)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, De	INJURY	28b. TIM		28c. INJU	JRY AT		28d. DESC		NJURY OC	CURED	
BY		ending rvestigation				M	1 🗌 Y	ES 2 [	NO					
28e. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office 29e. CERTIFIER (Chack only 2000) 2 MEDICAL EXAMINER: On the basta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.							r or Rural R	loute Number,						
2	29a. CERTIFIER (Check only	FYING PNYSIC	IAN: To the best of	my knowledge, de	eth occurre	d at the tin	ne, date	end place,	and due	to the cause	(a) and man	ner aa sta	ted,	
NO.														) and manner as stated,
w II	29b. SIGNATURE AND TITLE	OF CERTIFIER	,				T	29c. LICEN		IBER		29d. DAT	E SIGNED	(Month, Day, Year)
10 B	Kathabu	VW	ald m	ann	, K	20		00	86	18		<b>▶</b> N	lay 2	9, 1995
	30. NAME AND ADDRESS OF KATHAR CM	E WA	COMPLETED CAUS	OF DEATH (ITE	M 27) (Type, 2001	Print)	nnie	Ave	Si	lver	Sprin	а М	ח פו	0902
	SI. DATE FILED (MORRI, Day, P	Bell')	32. HEGISTRAI	R'S SIGNATURE		5 561	11113	AVE,	01	TAGT	Obtill	y, "	اع دا	3302
1	MAY 31 1	005	11: As	P .										

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8. BIRTHPLACE (State or Foreign

WEST VIRGINIA

3. TIME OF DEATN

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: WHITE

1 YES 2 NO

Approximate

OYEARS

OYEAR

IDAY

24b. WERE AUTOPSY FINDINGS

1 TYES 2 NO

26d. DESCRIBE NOW INJURY OCCURED

26f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

5/29/95

NA

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

OYEARS

Interval Batween Onset and Death

10:27 a.mv

retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit, BALTIMORE, MARYLAND 21215-0020 Page 6 may be hours after death. Pled in by the funeral or removal.

page 5 should notified

funeral director,

filled in by

I completely filled irial, cremation, o the

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examiner

medical

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BE

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Natural

2 Accident

4 Homicide

Sulcide

Pages 1, 2, 3 should

DIRECTOR: A hours after ditem 28 is 99 60

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely f	hour	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, th
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1995 EDITH C. MADIGAN May 29 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. November 25, 1912 HOURS 217-10-5869 1 M 2 X F 82 YRS. 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR WASHINGTON RAVENSWOOD NURSING HOME HAGERSTOWN RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION
TAKOMA PARK MONTGOMERY MD. 10a. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20912 U.S.A. 321 LINCOLN AVE. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Merried 2 Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) JOHN WM. RADER LAURA BELLE BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 MELODY IA., HAGERSTOWN, MD. 21740 RONALD HENDRICKSON 3810 20s. METHOD OF DISPOSITION 14 Buriel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE JUNE 1,1995 WASHINGTON, DC. SOLDIERS HOME CEMETERY 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE 22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012 23. PART I. Enter the disessea, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition AtheraseLEROTIC CARDID VASCULAR DISEASE resulting in death) DUE TO (OR AS A CONSEQUENCE OF ALZ HEIMER'S DISEASE. CERTIFICATION Sequentisity list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): PAKINSONS PISEASE cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated aventa POSSIBLE reaulting in death) LAST ASPIRATION PNEUMONIA PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? none 1 YES 2 NO ICIAN: 1 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER:
Nursing Home 5 Realdence 6 Other (Specify) HOSPITAL: 1 YES 2 NO PHYSI Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATN 28b. TIME OF INJURY

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER

NIA

28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

28c. INJURY AT WORK?

WORK? NA 1 YES 2 NO

836

Mourew nd 30. NAME AND ADDRESS PERSON WNO SOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

26e. DATE OF INJURY

NA

MILL STREF 21740 HAQ ERSTOWN

31. DATE FILED (Month, Day, Year) Daviden Roll 31 1995

32. REGISTRAR'S SIGNATUR

5 Pending

determined

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF REGISTRAR	MARYLAND / DEF	PARTMENT OF H	EALTH AND ME DEATH	NTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)		0.5	. 1 1 2.	DATE OF DEATH		3. TIME OF DEATH
	natherine	Ann	<u> </u>	illen	May 2		7:36Am
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birtho	MONTHS DAYS	IF UNDER 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)	8. BIRTH Countr	PLACE (State or Foreign
	372-28-4109 ¹□м²⊠	65 YR	is.	No	ov. 11, 1		higan
œ	9a. FACILITY NAME (If not institution, give street and number)			R LOCATION OF DEATH	1	9c. COUNTY OF D	EATH
DIRECTOR	Shady Grove Adventist Ho	spital	Rockvil	Le		Montgom	ery
RE	10a. STATE 10b. COUNTY		CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	Maryland Montgomery	I	Derwood				1 YES 2 NO
RA	10e. STREET AND NUMBER			ZIP CODE		10g. CITIZEN OF W	
FUNERAL	7441 Oskaloosa Drive	DENT EVER IN U.S. ARMED		erwood		United :	
	1 News Married 2 X Married FORCES?	1 YES 2 NO	If yes, spe	ENDENT OF HISPANIC ( city Cuben, Maxican, P		Black	— American Indian, , White, etc.
ВУ	3 Widowed 4 Divorced	E WAR ON DATES	1 TES	2 NO Specify:		Speci	White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind	NT'S USUAL OCCUPATIO	N st of working	166. KIND OF BUSI	NESS/INDUSTRY	
Ë	Elementary/Secondary (0-12) College (1-4 or	5+) Iffe. Do NO	OT use retired.)				
NA I	1. Z 17. FATHER'S NAME (First, Middle, Last)	Homen	naker			Home	
	Adam George Johe			16. MOTHER'S NAME (		lurname)	
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAJL	LING ADDRESS (Street ar	Helen An		State Zin Codel	
욘	James Robert Miller		Oskaloos				
	20s. METHOD OF DISPOSITION  1X Buriel 2 Cremetton 3 Removal from State	20h PLACEAND DA	TE OF DISPOSITION (No.	me of	DATE 200 100	ATION Chu or To	wn, State
	4 Donation 8 Other (Specify)	Gate of	or other place) Heaven Cem	etery 5/30	/95 Silv	er Sprin	ng, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	18	22. NAME AN	D ADDRESS OF FACILITY	M DEAOT F	uneral H	lome
	L > >.c. G		Gaith	st Deer Pa ersburg, M	D 20877		
	23. PART I. Enter the diseases, or complications shock, or heart fallure. List only one	that caused the death. D	Oo not enter the mod	de of dying, such s	cardisc or respire	etory srrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	100000	10-	250			Onset and Death
	resulting in death) a	PEROME	DIAR SIN	DIC			Hours
_	DUE	OR AS A CONSEQUENCE	TY NIF	11 mis			WEARC
0	Sequentially list conditions, if any, leading to immediate	TO (OR AS A CONSEQUENCE	E OF):				Smi27
SAT	cause. Enter UNDERLYING						
E	river muricited evening	TO (OR AS A CONSEQUENCE	E OF):				
CERTIFICATION	resulting in desth) LAST						
AL C	PART II. Other significant conditions contributing	to death but not resulting	ng in the underlying	csuse given in Par	t i. 24s. WAS AN A		WERE AUTOPSY FINDINGS
EDICA	CEREBLOUXEUMRAC	CIDENT,	ANEMIA		PERFORM		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	HOLEGIENZION	C	ASTROLLIE	STWAL BLE	ian i		OF DEATH?
	DIÉ TOBACCO USE CONTRIBUTE TO	CAUSE OF DEATH	YES   NO	UNCERTAIN [			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF D	OTHER:				
iYS	1 YES 2 NO 1 Inpatient	ER/Outpetient 3 DO	A 4 Nursing Home	5 Residence 8			
		OF INJURY 28b.	TIME OF SBC, INJU	RK?	d. DESCRIBE HOW IN.	JURY OCCURED	
ВУ	2 Accident Investigation 3 Suicide 6 Could not be 26s. PLAC	E OF INJURY — At home, ter		ES 2 NO	I. LOCATION (Street an	d Mumber or Rumi B	nute Number
TEO	4 Homicide detarmined buildi	ng, etc. (Specify)	The state of the s		City or Town, State)	a Namber of Harai N	bute rearriber,
COMPLET	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best	of my knowledge death occ	curred at the time date	and place, and due to ti	he device(a) and man	an an ababa	
N N	(Check only one)  2 MEDICAL EXAMINER: On the besis of						and manner as stated.
m C	29b. SIGNATURE AND TITLE OF GERTIFIEN	1		29c. LICENSE NUMBER		29d. DATE SIGNED	
00	alund & Tur	Lino		R306	97	MANY	26,1995
2	SO NAME AND ADDRESS OF PERSON WHO COMPLETED C	AUSE OF DEATH (ITEM 27)			2 1 1		3.00
	MA BEKKEDI ISEC	DO SHADY	grit R	DAD, K	Social	K M	7027 n
	JUN 01 1995	RAR'S SIGNATURE					
	JUN OT 1222 OL	-CONTROL -					

.... 11, 1929 Michigan

Shady Grove Adventist Hospital

Rockville

Montgomery

Montgomery Maryland

Derwood

7441 Oskalcosa Drive

Derwood

United States

Own Home

White

12

Homemaker

X

Adam George Johe

Helen Ann Blesz

7441 Oskaloosa Drive, Derwood, MD 20855

James Robert Miller

Gate of Heaven Cemetery 5/30/95 Silver Spring, MD DeVol Funeral Home

10 East Deer Park Drive Gaithersburg, MD 20877

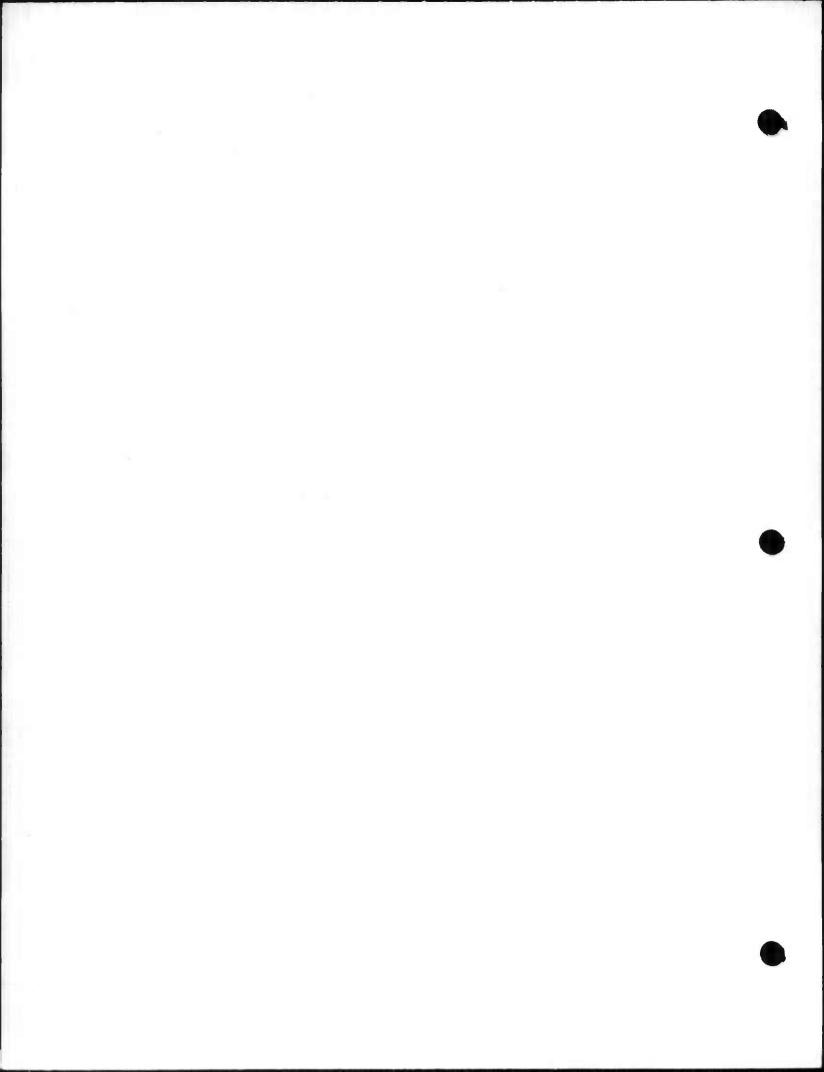
DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

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	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if	ERAL DIRECTOR: After this certificate has been signed by the attending obysician and completely filled in by the funeral
	O.R	PHO
	PITAL	ERAL

	LAWRENCE	G.		MARSHAI	L		2. DATE OF OEA MONTH MAY	TH DAY 30. 199	YEAR	TIME OF OEATH  3:15 P
	4. SOCIAL SECURITY NUMBER	100	E (In yrs. lest		OER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIFTT (Month, Day, Ye	Н		ACE (State or Foreign
	579-36-7539  9. FACILITY NAME (If not institution, give		3	YRS.			Feb 1,	1932	Washiu	ngton, D.C.
TOR	715 Dennis Avenu					Spring	EATH		gome:	
DIRECTO		tgomery		Silve	er Spi					Od. INSIDE CITY LIMITS?
IERAL	715 Dennis Avenue									
BY FUN	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1X YE IF YES, GIVE WAR OR U.S.M.C. 8/	S 2 NO		Black, W	- American Indian, White, atc.				
OMPLETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)		(Givi	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  ail Center Manager  Trade Association						
ЕС	17. FATHER'S NAME (First, Middle, Lest) Robert	Lo	18. MOTHER'S NAME (First, Middle, Maiden Surn Lomax Thelma							
TO B	190. INFORMANT'S NAME (Type/Print)  Dorothy Marshall	(Wife)		MAILING ADDR		nd Number or Rural	Route Number, City of	or Yown, State, Zip C	lode)	
	20a. METHOO OF DISPOSITION 1 ☐ Surfat 2 X Cremation 3 ☐ Rei		emetery, crem	ND DATE OF DISI	ce/		1	c. LOCATION — CI	ty or Town,	, Stata
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE L	Chesa Moos	apeake	ke Crematory 5-31 Beltsville, MD  22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910						
CERTIFICATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS	S A CONSEQU	JENCE OF):	Col	en C	an co			7 May
MEDICAL CE	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED?  1 YES 2 X NO									ERE AUTOPSY FINDINGS RILABLE PRIOR TO DMPLETION OF CAUSE DEATH? YES 2 X NO
	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE		H YES		UNCERTAI	N 🗆			
PHYSICIAN	EXAMINER?  1 YES 2 X NO	HOSPITAL: 1   Inpatiant   2   ER/Ou		OTH	ER:	e 5 💢 Rasidence	6 ☐ Other (Specify	)		
ву Рн	27. MANNER OF DEATH  28a. DATE OF INJURY  1   M Netural 5   Pending   Pendin							OW INJURY OCCU	RED	
8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUI building, atc. (Sc	RY — At hom pecify)	e, farm, street,	lactory, office		281. LOCATION (S City or Town,	treet and Number or State)	Rural Route	e Number,
COMPLET	29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYS	BICIAN: To the best of my kno ER: On the beals of examinating	lon and/or Im	th occurred at the	ne time, date ny opinion, d	and place, and due	to the cause(a) and time, data and place	d manner as stated ca, and dua to the	cause(a) an	nd manner as stated.
TO BE	296. SIGNITURE AND TITLE OF CERTIFIE  30. NAME AND ADDRESS OF PERSON W	1. Ch	an of the state of	27 (Sono Arion)	4.	29c. LICENSE NUI D41828	MBER			1995
	Clara S.P. Chan,		Green		r Dr.	#205, G	reenbelt	, MD 20	)770-	3532
	JUN 02 1995	Alia Davidson								
		·								DHMH-16 Day 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



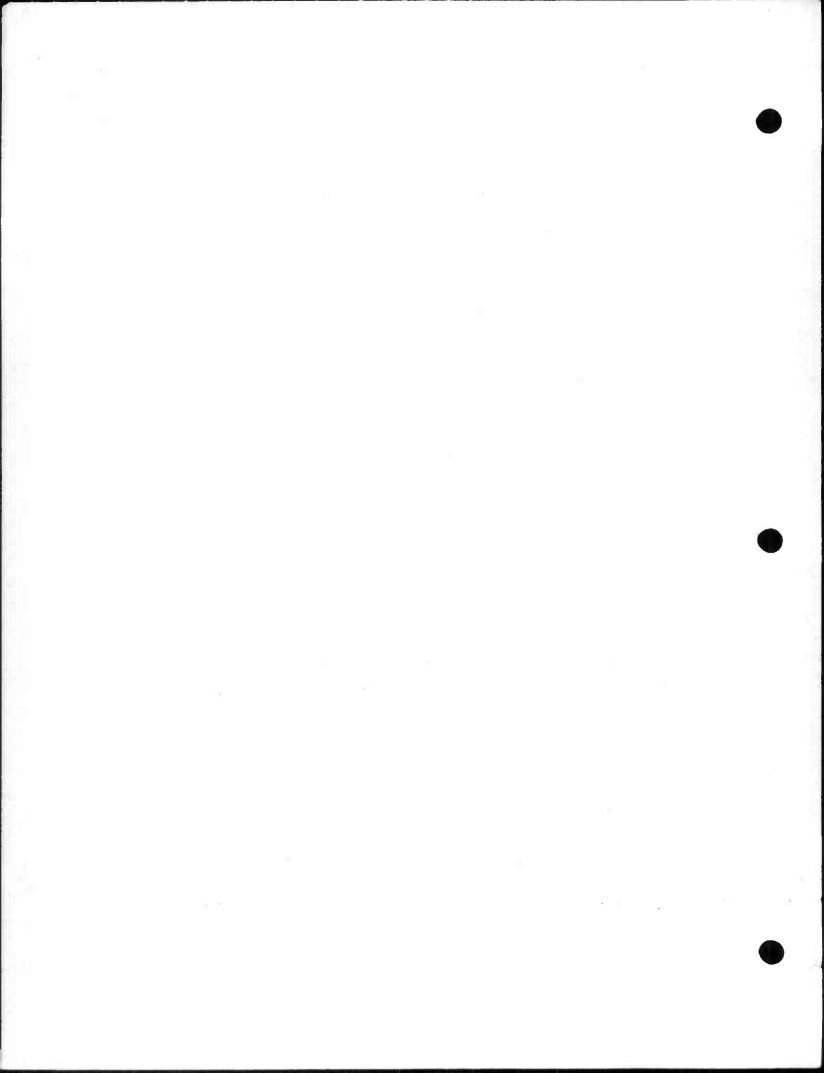
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Nem 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 6 filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove MPORTANT: If Nem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill se filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and con he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. MPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic e
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate to THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physice filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pric MPORTANT: If Hem 28 is marked, or litem 23 shows any injury, or other tr
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the atten he filed within 72 hours after death with the State Dept. of Health and Mental It MPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that 10 THE FUNERAL DIRECTOR: After this certificate has been signed be 6 filed within 72 hours after death with the State Dept. of Health at MPORTANT: If Hem 28 is marked, or Hem 23 shows any
10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law ra 10 THE FUNERAL DIRECTOR: After this certificate has bee he filed within 72 hours after death with the State Dept. C MPORTANT: If Nem 28 is marked, or Item 23 st
10 THE HOSPITAL OR ATTENDING PHYSICIAN: 10 THE FUNERAL DIRECTOR: After this certifica 10 fied within 72 hours after death with the St. 11 MPORTANT: If Hem 28 is marked, or it
THE HOSPITAL OR ATTENDING PAIN OF THE FUNERAL DIRECTOR: After the filed within 72 hours after death we filed within 72 hours after death w
THE HOSPITAL OR ATTE TO THE FUNERAL DIRECTO WE filed within 72 hours after MPORTANT. If Nom 28
O THE HOSPITA, O THE FUNERAL Pe filed within 72 MPORTANT: If

A	mended FOR 1 - STATE REGISTRAR	#2	3 STATE OF MA	ARYLAND C	/) DEPAR ERTIF	RTMENT	OF H	Moderate AND DEATH	T 9	ITAL HYGIEN	EJ	50	18587 un 7 y
	1. DECEDENT'S NAME (First, Edward	7501 AS		2. DATE OF DEAL MONTH Mernone May 2					KONTH DA	199	YEAR	3. TIME OF DEATH 5:00 P M	
	4. SOCIAL SECURITY NUMB 579-07-0287		1 🔀 M 2 🗆 F	AGE (In yrs. In	et birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	(4	MATE OF BIRTH Month, Day, Ybar) ne 10 1	912	Counti	PLACE (State or Foreign ry) York
OR	90. FACILITY NAME (If not in 9115 Paytle RESIDENCE OF DEC									unty of DEATH Ontgomery			
DIRECTOR	10e. STATE	10b. COUNTY	1		10c, CIT	Y, TOWN DI	R LOCAT	TION			MO	urso	10d. INSIDE CITY LIMITS?
	MD  10e. STREET AND NUMBER	Mon	tgomery			Pot	oma	. ZIP CODE			40- 017	1754 05 1	NAT COUNTRY?
FUNERAL	9115 Payt	ley Br	idge Lane				"		085	4	10g. CI1	USA	WHAI COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 2 3 Divor		12. WAS DECEDENT FORCES? 1 FIF YES, GIVE WAR	VER IN U.S. AI YES 2 DI DR DATES	RMED NO	н	yes, sp	ecity Cuban, Mexico 2 ND Specific	an, Pue	RIGIN? (Specify Yes erto Rican, etc.)	or No—	14. RACE Black Speci	E — American Indian, k, White, etc.
COMPLETED	15. DECI (Specify only Elementary/Secondary (0	EDENT'S EDUC highest grade	CATION completed)  College (1-4 or 5+) 2	in (C	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  NOT use retired.)  Self-employ								
BE COM	17. FATHER'S NAME (First, Mi	ddle, Lesi) Merno	one					18. MOTHER'S NA	ME (FI	Unknown			
TO B	190. INFORMANT'S NAME (7) Angela G. Me					AG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paytley Bridge Lane Potomac, MD 20854							20854
	20a. METHOD OF DISPOSITION  1								Alex Joseph	andr:	city or To ia ' er's	Virginia Sons	
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.  Approximate interval Between										Approximata Interval Between Onset and Death		
PHYSICIAN: MEDICAL C	PART II. Other alignificer	nt conditions	contributing to de	eth but not	resulting I	n the und	deriying	cause given in	Part I	24s. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
AN:	DID TOBACCO US		RIBUTE TO CAUS					UNCERTAIL	N [	1			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2X ND  26. PLACE OF DEATH (Check only one)  OTHER:  1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 8 Other (Specify)												
ВУ РН	27. MANNER OF DEATH  1 Netural 5 Pending (Month, Day, Year)  2 Accident Investigation				28b. TIMI	-	28c. INJI WO	URY AT		DESCRIBE HOW IN	JURY OC	CURED	
	3 Suicide 8 C	Could not be latermined	28e. PLACE DF IN building, atc	NJURY Al ho . (Specify)	me, larm, a	treet, lector	ry, office		281. [	LOCATION (Street at City or Town, State)	nd Number	or Rural A	loute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTI	FYING PHYSIC	CIAN: To the best of my	knowledge, de	ath occurre	d at the tim	ne, data Inion, de	and place, and due	to the	cause(s) and man	ner as stat	led. ne cause(s)	) end manner as stated.
BE	29b. SIGNATURE AND TITLE		Hon	u				29c. LICENSE NUR D 2006	<b>VBER</b>		29d. DAT	E SIGNED	(Month, Day, Year)
일	30. NAME AND ADDRESS OF	DEDGON -	CONTRACTOR CALLER	OF DEATH COT		0.1							

D 20065

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Eva M. Morell, M.D., 6000 Executive Blvd., Rockville, MD 20852 31. DATE FILED (Month, Day, Year)

JUN 02 1995 32. REGISTRAR'S SIGNATURE



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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heath. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	THE CONTRACT OF STREETING PROPERTY TO STREET OF STREET STREET OF STREET OF STREET OF STREET
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIE							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH					
	James	Richard Mc	ore			June 2,	1995 T	7:40 AM M					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (/	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.1	BIRTHPLACE (State or Foreign					
	241-34-6576  9s. FACILITY NAME (If not institution, give s	YRS.	MONTHS DAYS	HOURS MIN.		30. 1926 North Carolin							
R	201 Middleton (	i		or LOCATION OF DI	EATH	9c. COUNTY	of DEATH Harford						
DIRECTOR	RESIDENCE OF DECEDENT						1	arioru					
IRE	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT				10d, INSIDE CITY LIMITS?						
	Marvland 100. STREET AND NUMBER		1404	Church		1 TYES 2 X NO							
FUNERAL	201 Middle	ton Court		100	21028		iog. Citizen	10g. CITIZEN OF WHAT COUNTRY?  USA					
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC		NIC ORIGIN? (Specify	fes or No — 14.	RACE American Indian.					
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES		If yes, sp	ecify Cuban, Maxica 2 NO Specifi	n, Puerto Rican, atc.)		Black, White, atc. Specify:					
		1951 - 19		1000				white					
TE	15. DECEDENT'S EDU- (Specify only highest grade	CATION completed)	(Give kind of v	USUAL OCCUPATION	ON st of working	16b. KIND OF E	USINESS/INDUST	RY					
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us										
MO	17. FATHER'S NAME (First, Middle, Last)	5+	Statist	cician	40 MOTHERIC MA	ME (First, Middle, Meid	Gover	nment					
	Richard Isaac Mo	2020			STATE OF THE PARTY		and the same of						
BE	19a. INFORMANT'S NAME (Type/Print)	Dre	19b. MAILING	ADDRESS (Street a		(nmn) Cr		(a)					
٩	Barbara R. Moore					, Churchy							
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE O	F DISPOSITION (Na			OCATION — City						
	4 Donation (5 D Other (Specify)	HAN R	atery, crematory or of A. Fer	ris & Co	o., Inc.	6/3/95 W	. Cheste	er. PA					
	21. SIGNATURE OF FUNERAL BERVICE LIS	ingles / / or	.41	22. NAME AN	D ADDRESS OF FA	CILITY							
	MANN///////////////////////////////////	-1/1/92	1000-					Home, P.A. , Md. 21009					
$\neg$	23 PART I. Enter the diseases, or o	omplications that caused	the deeth. Do n	ot anter the mo	de of dying, auc	h aa cerdiac or rea	piratory arreat,	Approximata					
	IMMEDIATE CAUSE (Finel	List only one ceuse on ea		7	1			Interval Between Onset and Death					
	disease or condition resulting in death)	METROSH	77	0/00/	R			411.00					
	Todating it douting	DUE TO (OR AS A	CONSEQUENCE OF					192					
Z	Sequentially list conditions (b.												
Ĕ	If any, leading to immediate cause. Enter UNDERLYING												
5	CAUSE (Disease or Injury	CDUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (ON AS A	CONSEQUENCE OF	<b>)</b> -				j					
E		1											
AL	PART II. Other aignificent condition	s contributing to deeth bu	it not resulting i	n the underlying	cauae given in		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
20						1 YES		COMPLETION OF CAUSE OF DEATH?					
ME							,	1 - YES 2 - NO					
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI				UNCERTAIN	4 🗆							
₫	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	86. PLACE OF DEAT	H (Check only one) OTHER:									
14S	1 VES 2 NO	1   Inpatient 2   ER/Outpa				6 Other (Specify)							
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME	JRY WO	RK?	28d. DESCRIBE HOW	INJURY OCCURE	ED .					
B	2 Accident Investigation 3 Suicide 6 Could not be	280. PLACE OF INJURY	— At home, ferm is		ES 2 NO	281. LOCATION (Street and Number or Rural Route Number,							
COMPLETED	4 Homicide 6 Could not be determined	building, atc. (Specia	fy)	in on, rectory, orrice		City or Town, Sta	(and reumber of re	oral House Number,					
۳ ا	29a. CERTIFIER A CERTIFYING PHYSI	CIAN: To the best of my knowle	des desta	4:14: 4: 4:									
M I	(Check only one) 2 MEDICAL EXAMINE	R: On the basis of examination	investigation	o at the time, data n. In my opinion, d	and place, and due	to the cause(e) and m	enner as stated.	use(s) and manner as atriad					
- 11	296. SIGHABORE AND STILE OF CERTIFICE		7										
띪	Muley VIII	when I			29c. LICENSE NUN	- < /	29d. DATE SIG	RNED (Month, Day, Year)					
유	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	TH (FTEM 27) (Type	Print)	0000	11	16/	0/70					
	MICHAEL AL	IERBACH C	1000 F	RRNKI	N 59	Do K	1/4/0	R 21237					
	31. DATE FILED (Month, Day, Year)	2. REGISTRAR'S SIGNA	TURE .	100	1	U, U,	1100	0,001					
- 1	JUN 0 5 1995	Jalin Mucken	Varball,		//			I					

BALTIMORE, MARYLAND	ospit
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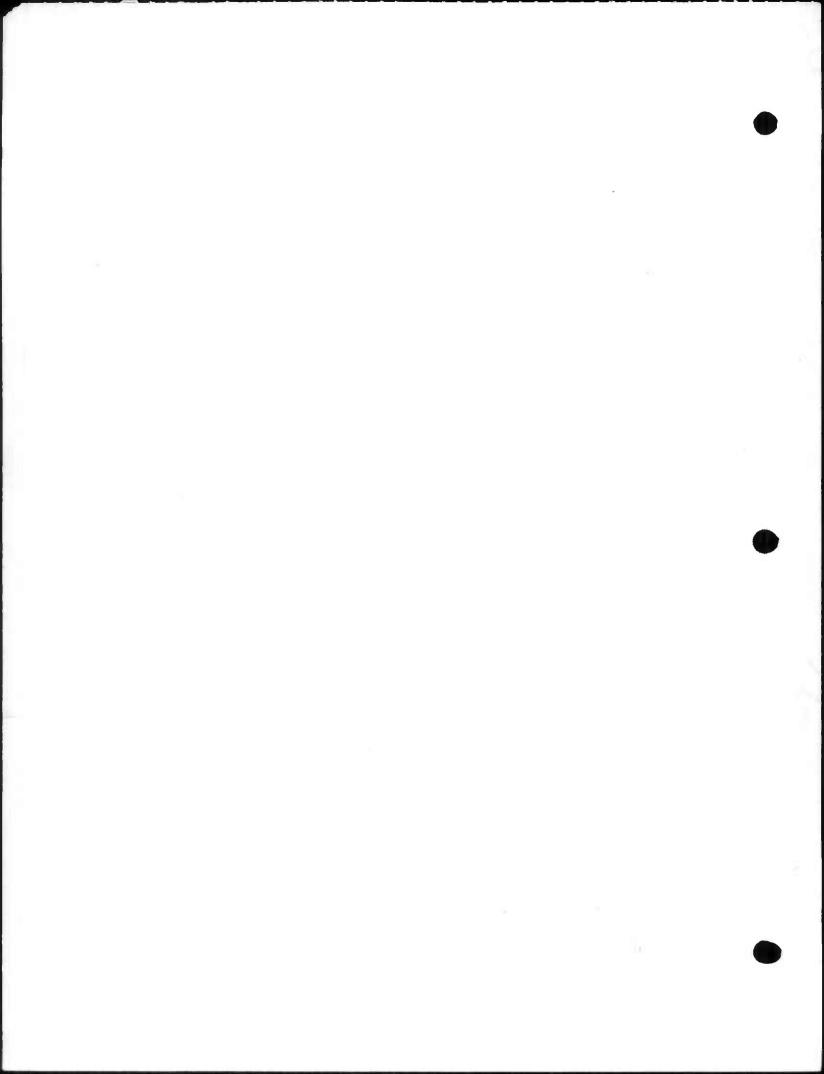
for use as the

attending physician.

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH June 1, A. Robert Merrion 1995 9:35 A M 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) June 20 1906 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 X M 2 | F 155-28-4174 88 YRS. PA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Solomons Nursing Center Solomons Calvert RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Calvert Solomons T YES 2 NO toe STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 13325 Dowell Road 20688 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 3 🔀 Widowed 4 🗌 Divorced white 15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elamentary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Supervisor Federal Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Anthony Marion Susanna Colgett 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur B. Merrion 1080 Plum Point Road Huntingtown, MD 20639 20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1 ☐ Buriel 2 💢 Cremetion 3 ☐ Removal from State Metropolitan Crematory 6-2-95 4 Donation > Other (Specify) Alexandria. VA 22. NAME AND ADDRESS OF FACILITY 'e Rausch Funeral Home, PA Owings, MD 20736 22. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. Liet only one cause on each ilna. Approximate intarvai Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition . END STAGE 1 year recuiting in death) DUE TO (OR AS A CONSEQUENCE OF) CARDIAC ARRHYTHMIAS 5 years Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DEMENTIA, DECUBITUS ULCER 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) QTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1 | Inpetient 2 | ER/Oulpetient 3 | DOA 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 1 Natural 28b. TIME OF 26c. INJURY AT WORK? 26d, OESCRIBE HOW INJURY OCCURED 5 Pending M t YES 2 NO Accident 26e. PLACE OF INJURY — At home, term, street, lactory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 16/1/95 D36969 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
SCARIA MATHEW MD, 11910 H. G. TRUEMAN L USBY MD 20657 32 REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) JUN - 6 1995



BALTIMORE, MARYLAND 21215-0020 HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing a not need to require that the law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

PHYSICIAN:

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1X YES 2 | NO 27. MANNER OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE REGISTRAR	STATE OF MA			RTMENT				MENTA	L HYGIEN					
	t. DECEDENT'S NAME (First, Middle,									OF DEATH			3. TIME OF DEAT	гн	
		FOX McN	VEIL						JUN	E I	r, 19	995	6:15	AM	
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (In yrs. les	st birthday)	IF UNDER 1	-	IF UNDER		7. DATE	OF BIRTH		6. BIRTH	HPLACE (State or Fo	veign	
	578-66-2527		18	YRS.	MONTHS 6	DAYS	HOURS	MINS.	Dec	h. Day, Year) 23,1	1946 Washington, D.C				
	9e. FACILITY NAME (If not institution,	give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE											
PO P	6011 ARMOR D				CLI	INT	ON				PR	PRINCE GEORGES			
E	RESIDENCE OF DECEDEN	COUNTY		I inc CIT	Y TOWN OR	LOCATI									
DIRECTOR		cince George'	S	10c. CITY, TOWN OR LOCATION  Clinton							10d. INSIDE CITY LIMITS?  t YES 2XX				
A	10e. STREET AND NUMBER					101.	ZIP CODE	E			10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	6011 Armour	Drive					2073	35				11.5	S.A.		
5	11. MARITAL STATUS	12. WAS DECEDENT EX	VER IN U.S. AR	MED	13. W	IS DECE	ENDENT O	F HISPAN	NIC ORIGIN	17 (Specify Yes	s or No—			90.	
- 11	1 Never Married 2 Merried	FORCES? 1 [] IF YES, GIVE WAR		10	If y	yes, spec	cify Cubar	n, Mexica Specify	in, Puarto I	Ricen, etc.)		14. RACE — American Indian, Black, White, etc. Specify:			
ВУ	3 Wildowed 4 Divorced				1 YES 275 NO Specify:						Black				
TED	15. DECEDENT'S (Specify only highest	3 EDUCATION 1 grade completed)	16a. DE(	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired,)											
COMPLET	Elementary/Secondary (0-12)	lite.		,											
M		4		Home	emaker	<u> </u>					Home				
	17. FATHER'S NAME (First, Middle, Las Robert						16. MOTH			Middle, Maiden					
B	19e. INFORMANT'S NAME (Type/Print)	Fox		Eleanor Lowe											
2	Richard McNeil	•	196	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)											
1		ur Drive Clinton, Maryland 20735  White June 5, Date   20c. LOCATION - City of Town, State													
	20e. METHOD OF DISPOSITION 1 Burlet XXX remetion 3	Removal from Stata	cemetery, cre	malory or o	ther place	TUTT	ള വ	me :	5, OATI						
	Resurrection Cemetery 1995   Clinton, Mary											aryland			
	21. SIGNATURE OF PUNERAL SERVICE		22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, In							e, Inc.					
	55.7.		6633 Old Alexandria Fe						la Fer	rry Rd Clinton, Md					
	23. PART I. Enter the diseases,	, or complications that co	eused the de	eth. Do r	not enter th	ne mod	la of dyle	ng, aucl	h aa card	20735	iratory arr	reat.	Approxima	ata	
	shock, or heart fell IMMEDIATE CAUSE (Final	llure. List only one cause	on each line.	).							1		Interval Be	etween	
	disease or condition	Hun. T.	-, 1	1.7	-	1	4	1	1 /	volu		\	Onset and	Death	
Н	resulting in death)	DUE TO (OF	R AS A CONSEC	TALL DI PILENCE OF	2005C	Yes	ohe	1	Me	volu	les d	rse	ine		
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E	resulting in death) LAST														
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MEDICAL	PART ii. Other algnificent cond	iltions contributing to dee	ath but not re	eaulting i	n the unde	rlying	cause g	iven in i	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FIN		
ĕ I									_	1 YES 2	NO I		COMPLETION DF C		
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

26. PLACE OF DEATH (Check only one)

HOSPITAL: t ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY

28c. INJURY AT WORK?

26d. DESCRIBE HOW INJURY OCCURED

> 29c. LICENSE NUMBER O.C.M.E

1 YES 2 NO 26e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)

28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER wledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. (Check only one)

on, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and manner ee stated. 296 SIGNATURE AND TITLE OF CERTIFIES

OF OEATH (ITEM 27) (Type, Print)

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Penn Street, Baltimore, Maryland 21201

29d. DATE SIGNEO (Month, Day, Year)

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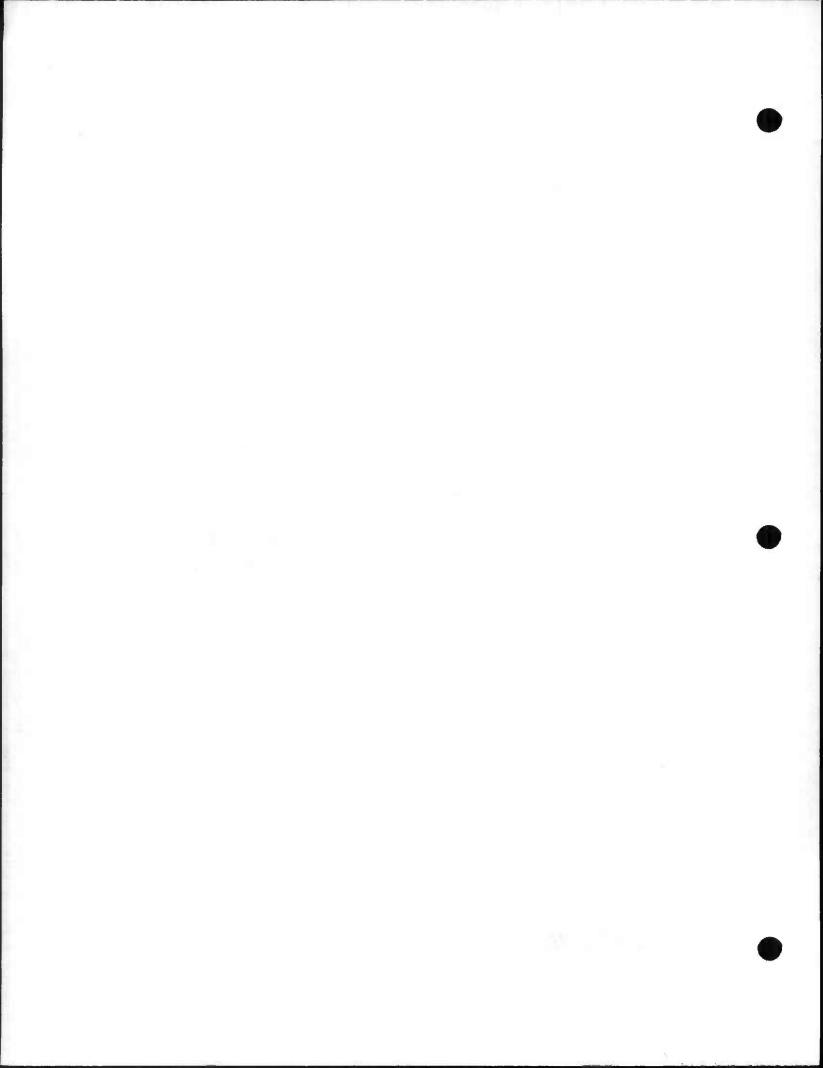
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31. DATE FILED (Month, Day, Year)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR SYLVIA June 4:40 P 11 NMN MEANS 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 - M XX F 236-40-2754 YRS. Sept. 26 1909 West Virgini permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 751-C Heather Ridge Drive Frederick Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? the burial-transit 751-C Heather Ridge Drive 21702 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuben, Mexican, Puerto Rican, stc.)

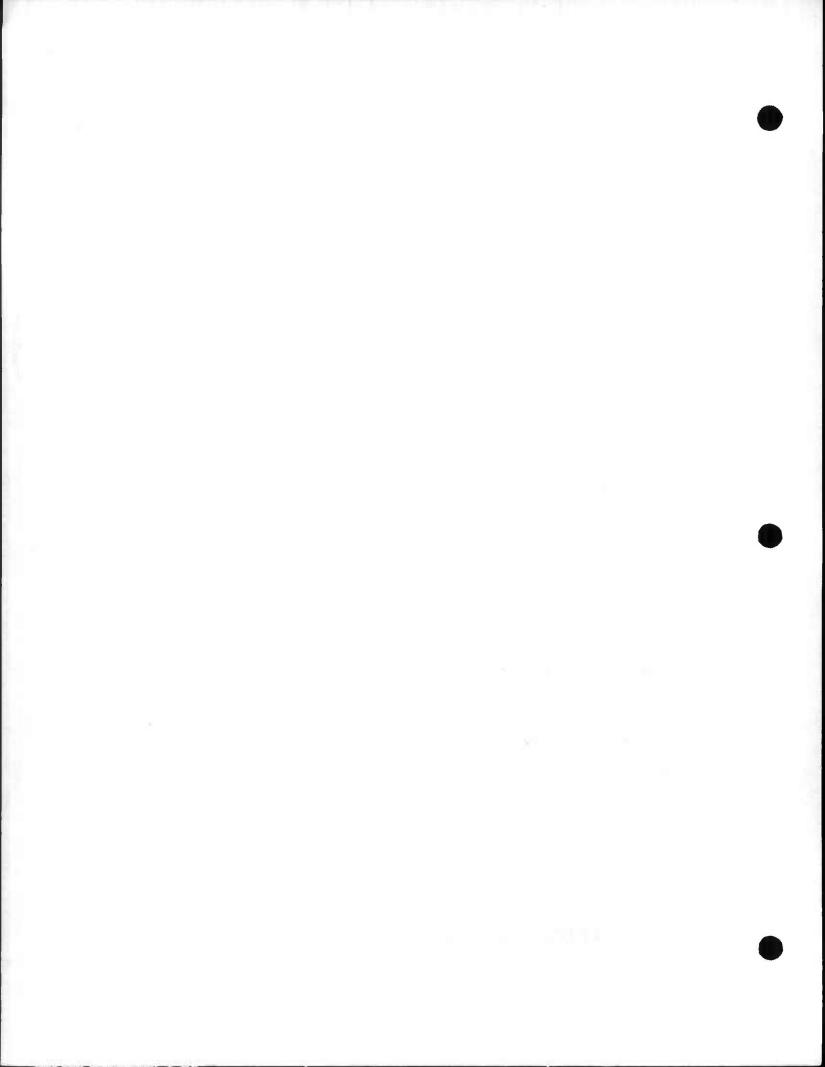
1 YES XIX NO Specify: 14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Merried BY Specify: 3XX Widowed 4 Divorced White 338 COMPLETED 16. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16h, KIND OF BUSINESS/INDUSTRY use (Specify only high detached for College (1-4 or 5+) 5 Cook Food once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at Irvin Edwards BE Effie Beckett page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Phyllis Coleman 751-C Heather Ridge Drive Frederick, MD 21702 90 20a, METHOD OF DISPOSITION
19 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must the funeral director, Cometery crematory or other piece)
WoodTand Cemetery 4 Donation 5 Other (Specify) \_ 6/6/95 Cedar Grove, West Virgin medical examiner 21. SIGNATURE OF EMBERAL BERVICE-EXCENSES 22. NAME AND ADDRESS OF FACILITY hours after death. Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD 23 PART / Enter the diseases, or complications that caused the death. Do not snter the mode of dying, such as cardisc or respiratory arrest, filled in by Approximate shock, or heart fallure. List only one cause on each lins. interval Between 6 IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition HYPEASENSITIVE CAPOTID SINUS SYNDROME 2 years completely resulting in death) traumatic event, DUE TO (DR AS A CONSEQUENCE OF): METASTATIC SQUAMOUS CELL LARYNGEAL CANCER Hygiene prior to burial. the attending physician and Mental Hygiene prior to burn CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the amy AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 27 NO Shows : Boc 1 TYES 2 NO DIRECTOR: After this certificate has been hours after death with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN PHYSICIAN: 8 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only 2 The The HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 26e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED is marked, 1 Natural 1 YES 2 NO BY Investigation Accident 28e. PLACE DF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 6 Could not be determined COMPLETED 28 4 Homicide Item 8 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. THE HOSPITAL ( THE FUNERAL D filed within 72 h Ξ 2 MEDICAL EXAMINER: On the TO THE HOSPITA
TO THE FUNERA
DE filed within 7. of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end menner ea stated. 20b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) MA 031761 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 501 W. SAVENTH ST FREDERICK, MD

32. REMISTRARIS SIGNATURE



THE HOSPITAL DE ATENDING PHYSICIAN: The law requires that the death certificate be executed withing—Knows after death. Page 6 may be retained by the hospital or attending physician.  TO THE HUSPITAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funetal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. city or Hearth and Mental Hygher prior to burial, cremation, or removal.  IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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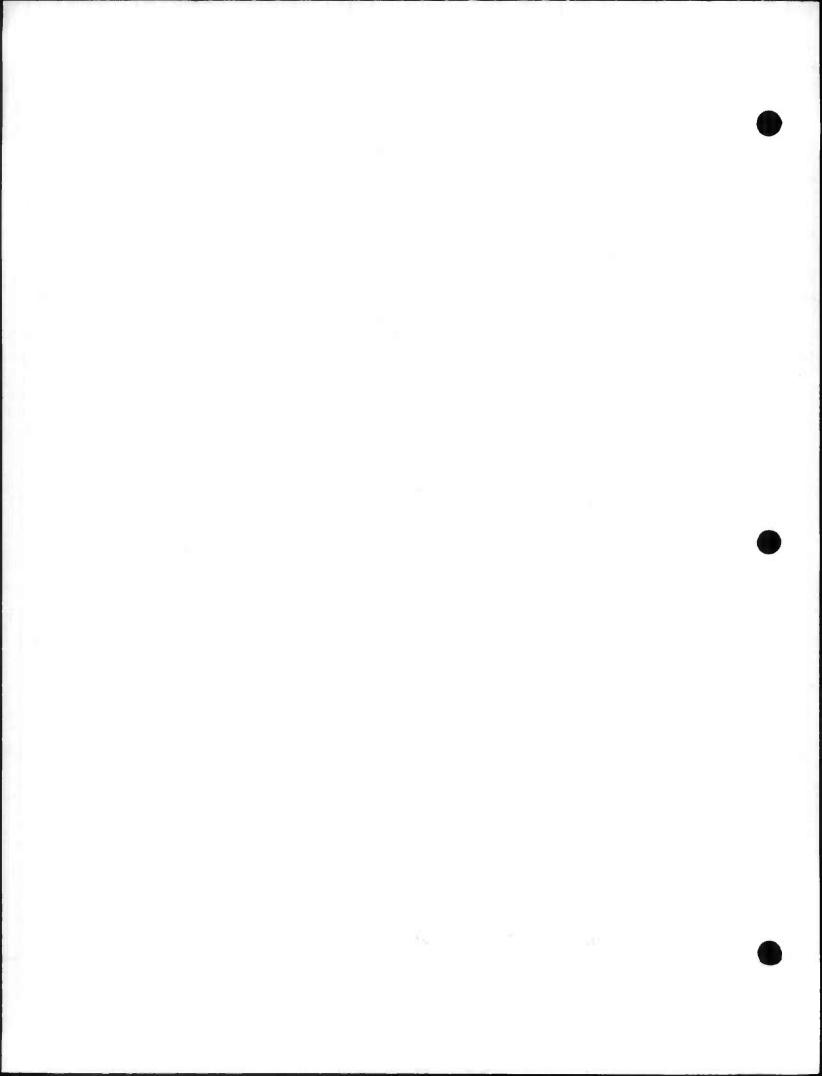
	1 - STATE REGISTRAR	STATE OF N	IARYLAND /							HYGIEN REG. NO.	E		
	REGISTRAR  CERTIFICATE OF DEATH  1. DECEDENT'S NAME (First, Middle, Leat)  2. DATE OF DEATH										3. TIME OF DEATH		
	Marshall Leroy Mitchell							MONTH DAY YEAR				1:05 A M	
				AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				7. DATE OF	BURTH		S BIRTHI	PLACE (State or Foreign	
	220-18-2286	1 <b>X</b> (XM 2 □ F	71	YRS.	MONTHS DAYS HOURS MIN.			April 29,1924		1924	Mar	yland	
	9a. FACILITY NAME (If not institution, give a	7.1		9h CIT	/ TOWAN C	R LOCATI	ON OF DE		27,		NTY OF DE		
œ	Frederick Memor		ital			eder		ON OF DE	-AIH			leric	
DIRECTOR	RESIDENCE OF DECEDENT												
Ĕ.	10a. STATE 10b. COUNTY				Y, TOWN		ION						10d, INSIDE CITY LIMITS?
	Maryland Fred	lerick		F	reder	cick							1 TES 2 NO
FUNERAL	100. STREET AND NUMBER 7716 Edgewood C	hurch Ro	ad	d 101, ZIP CODE 21702					10g. CITIZEN OF U.S.A.			ZEN OF W	HAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDEN	EVER IN U.S. AF	RMED	13.	WAS DEC	ENDENT C	F HISPAN	VIC ORIGIN? (S	Specify Yes	or No-	14. RACE	- American Indian,
	1 Never Married 2 Married	Jan. 21, 1	YES 2			Il yes, apo	2XXNO	n, Mexica Specifi	n, Puerto Rica	in, etc.)		Black, White, etc.	
ВУ	3 Widowed 4 Divorced	Jan. 21, 1	943-Jan.3	,1946								W	hite
ᇤ	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	/G	CEDENT'S	work done	CCUPATIO	N st of worldr	10	18b. Ki	ND OF BUS	INESS/IN		
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+	life	ecur:	se retired.)			•	Po	wer 1	DI ant	_	
MP	10		.51	ecur.	LLy	)TTT(	-ET		10	wer i	Lain	-	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	MTTCH	TOT T						ME (First, Mide			TATE	
BE	Gorman Victo	r MITCH	<u> </u>				Ma	amie	Cath	erine	e KI	LINE	
2	19a. INFORMANT'S NAME (Type/Print)	1 . 7.7							Route Number,				01.700
	Mrs. Gladys E. Mi			//10	rage.	WOOC	1 Chi	ırcn	Rd., Frederick, Md. 21702				. 21/02
	209 METHOD OF DISPOSITION  1 Disposition 3 Rame	oval Irom Stata	20b. PLACE						DATE 20c. LOCATION — City or Town, State				
	4 Donation 5 Other (Specify)		Rocky	Sprin			_		1995	Fred	derio	ck, M	aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSE			22. Is	NAME AN	D ADDRE	SS OF FA	asford	РΔ	Fin	paral	Home
	Kichard E-	DIA	MOO	255									Md. 21701
	23. PART I. Enter the diseases, or o	omplications that	caused the de	eath. Do	not enter	tha mo	de of dy	ing, suc	h ss cerdiac	or respi	ratory an	rent.	Approximate
	shock, or heart feliure. List only one cause on each lina.												
	IMMEDIATE CAUSE (Final disease or condition )												
- 1	disease or condition resulting in desth) a. Christophylical disease or condition and Disease years  Due to (or as a consequence de):												
2													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):											
8	cause. Enter UNDERLYING												
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	OUENCE O	F):								
F	resulting in death) LAST	1,											
2	DADT il Other electionet condition		contributing to deeth but not resulting in the underlying cause given in										
CAL	A \ 1								Part I. 24	PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	Atherosol	450110	Hes	11	ارد	See	256		1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
×													1 _ YES 2 _ NO
ž	DID TOBACCO USE CONTI	RIBUTE TO CA					UNC	ERTAIN	4 🗆				
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	CE OF DEA	TH (Check								
YSI	1 TYES 2 NO	1 Sepatient 2	ER/Outpetient 3	□ DOA			• 5 □ Re	sidence	6 Other (S	pecify)			
PH	27. MANNER OF DEATH	28s. DATE OF (Month, De		28b. TIM	IE OF	28c. INJI			28d. DEŞCR	IBE HOW IN	JURY OC	CURED	
ВУ	1 Natural 5 Pending Investigation				М	1 🗌 Y	ES 2	NO					
	3 Suicide 8 Could not be	28s. PLACE Of building,	F INJURY — At ho	ome, ferm,	street, lac	tory, office	1		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				oute Number,
	4 Homicide determined									,			
7	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledge, de	eth occurr	ed at the t	time, data	and place.	and dua	to the cause(	a) and man	nor as atal	led.	
COMPLETED	onel												and manner as stated.
E C	296. SIGNATURE AND TITLE OF CERTIFIER	r-/1				T		NSE NUN					Month, Day, Year)
œ	/ AIMA	4/1	mely	> ,	47	\		6428			▶ C	0/1	91
2	38. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	OF DEATH (ITS	M-27) (Type	Print)	/	UTD 7.5		75				117
1	Dr. Casper E. C	line III	MD 30	0 Wes	st Ni	inth	Stre	eet.	Frede	rick	. Md	217	01
	31. DATE FILED (Month, Day, Year)	32. REDISTRA	R'S SIGNATURE		1			,			,		
	JUN 0 2 1995	y yelin	R'S SIGNATURE	arlet									



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VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floor death countries that the death certificate be executed within a floor death. Page 6 may be retained by the hospital or attending physician.	After thi	le m
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: After the be filed within 72 hours after dea	MADOUTANT. If Hem 29 is m

							9	5	18593	
FOR 1 - STATE REGISTRAR		RYLAND / DEPA CERTIF		OF DEAT		NTAL HYGIE REG. N				
1. DECEDENT'S NAME (First, Middle, Las						DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH	
John Waring Morr	7								2035	A
4. SOCIAL SECURITY NUMBER 2 17-52-1018	5. SEX 6.	AGE (In yrs. last birthday) 46 YRS.		UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF (Morith, D. March			949	PLACE (State or Foreign) aryland	n	
9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TO	WN OR LOCATION				JNTY OF D		
24950 Collins Wh	Eden				Wio	comic	0	_		
	100.00					ry, town or location  Eden				
100. STREET AND NUMBER 24950 Collins		10f. ZIP CODE 2 1822					WHAT COUNTRY?			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	If y	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea if yea, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ YES 2 ☑ NO Specify:					E — American Indian, k, white, atc. iiy. White			
15. DECEDENT'S Et (Specify only highest gra Elementary/Secondery (0-12)		16a. DECEDENT' (Give kind of life, Do NOT	f work done duri	IPATION ng most of working		16b. KIND OF 8	USINESS/IN	DUSTRY	Milec	
11		Line	Forema	in		Cons	truct	ion		
17. FATHER'S NAME (First, Middle, Lest) Willard					rs name (	First, Middle, Meid		mall		
19e. INFORMANT'S NAME (Type/Print)	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING					Number, City or T	own, State, Zi	(p Code)		_
Jeanie Blizzar	Jeanie Blizzard 3572					, Eden, MD 21822				
20a. METHOD OF DISPOSITION  1 XBurlat 2 Cremation 3 Removal from Stata  4 Donation 5 Other (Specify)  Allen Ce				F DISPOSITION (Name of place) Detery 6/8				Allen, MD		
21. SIGHAFURE OF POWERAL SERVICE LICENSEE 22. NAME A							Alle	n, M	D	_
N Kan	olloway Ol Snow	Funer	al Home							
23, ARTI. Enter the diseases, o shock, or hasrt failure interest of the condition resulting in dasth)	on each fine.	ad	i mode of dyni	y, auch aa	Carciac of rea	iprintory ai	reat,	Approximata Interval Batw Onset and De	eat	
Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Self-inflicted  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other algorificant condition	polificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTO PERFORMED:  1 □ YES 2 🗶 N						ORMED?	? AVAILABLE PRIOR COMPLETION OF		
DID #001.000 1/07						.			1 TES 2 NO	
25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	TO CAUSE OF DEATH YES NO NO								_
EXAMINER?	HOSPITAL:	R/Outpatient 3 DOA	OTHER:	Home 5 X Real						
27. MANNER OF DEATH	28a. DATE OF IN.	JURY 28b. TII	ME OF 26	c. INJURY AT		d. DESCRIBE HOY	V INJURY OC	CURED		_
1 Natural 5 Pending	(Month, Day, 06-04-9		UURY M	WORK?	NO S	elf-inf	licte	7		
2 Accident investigation 28a PLACE OF INJUSTY — 84 home farm streat factors office						LOCATION (Street City or Town, Ste	et and Numbe		Route Number,	_
4 Homicide determined	arf Roa	ıd	E		i, Store) Marvland					
Secretary of the determined building, etc. (Specify)  24950 Collins Wharf Road  29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause of the collins									a) end menner as state	d.
29b. SIGNATURE AND TITLE OF CERTIF					ISE NUMBER		_		(Month, Day, Year)	
NA CESS		$\infty$	DME							
30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CAUSIL	OF DEATH (ITEM 27) (Typ	D.M.E.	D035	ココ		1 0	6-05-	-95	_
John T. Bulkeley 31. DATE FILED (Month, Day, Year)	M.D., 108	Pine Bluf	f Road	l, Salis	bury,	MD, 21	801			_
JUN 06 199	5 Julia dans	esignature eleon hardall								



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AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, name 5 should be detached for use as the burial-traneir person 1.2.2 should	e filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT If Item 28 is marked or item 23 shows any intervent retirements assembled assembled assembled as assetted at account.
TAL OR A	RAL DIREC	72 hours	If Hem
HE HOSPI	HE FUNER	ed within	DRTANT
0	E	100	4

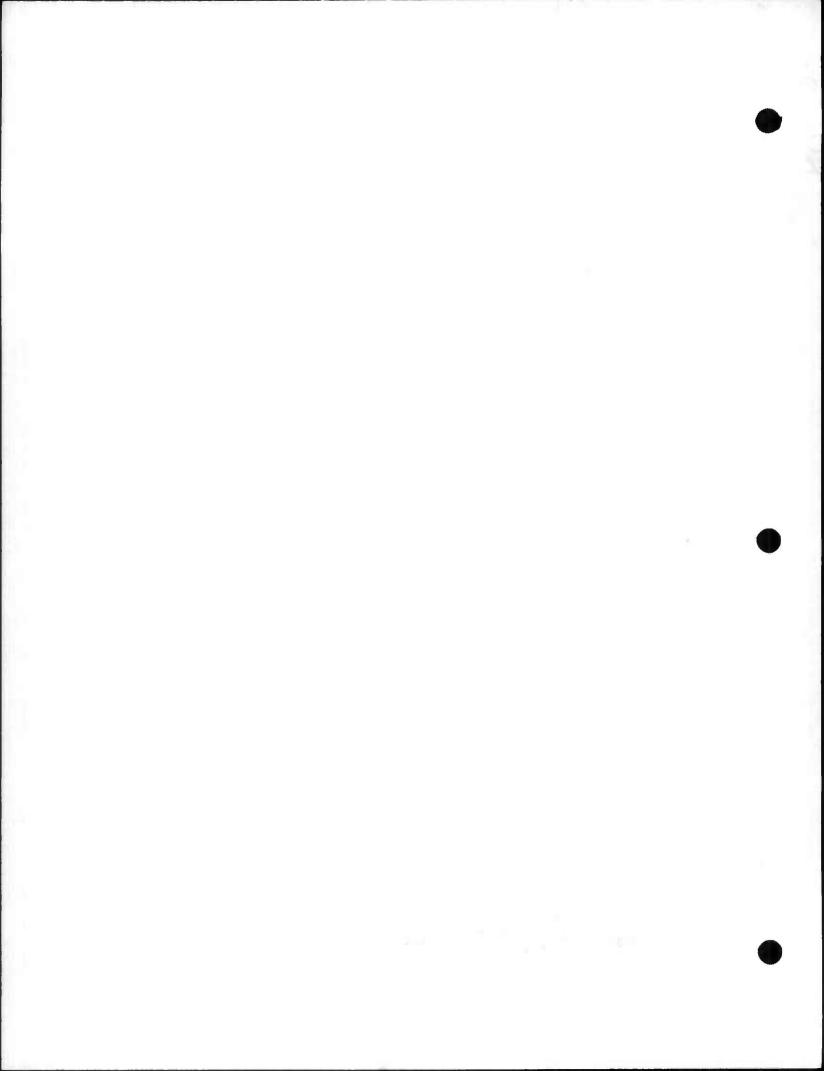
95 18594 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN ARVE PRESTON WHEELER MONTH 2 2105 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 79 DAYS HOURS MIN. 221-05-7066 1 X M 2 - F YRS December 29, 1915 Delaware 9e. FACILITY NAME (If not institution, give etreet end number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Wicomico Salisbury 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Fairground Drive 21801 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OF DATES WW II 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicon, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY 1 YES 2X NO Specify: Specify 3 Widowed 4 XXDivorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Instrument mechanic DuPont Inc. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) L. Marvel Carrie Brooks Wheeler BE 19e. INFORMANT'S NAME (Type/Print) 19th MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)
4 108 Harvest Lane, Salisbury, MD 21801 2 Glenn Marvel 20a. METHOD OF DISPOSITION
1 X Burlet 2 Cremetion 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Odd Fellows Cemetery 4 Donation & Other (Specify) 5/30 Seaford, DE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 21. SIGNATURE OF EUNERAL SERVICE LICENSES 00301 501 Snow Hill Rd., Salisbury, MD 21801 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feiture. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) Minutes DUE TO (OR AS A CONSEQUENCE OF) Jane CERTIFICATION peare Minutes Sequentially ilst conditions, DUE TO/OR AS A CONSEQUENCE OF): if any, issding to immediate e. Entar UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resuiting in dasth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO PHYSICIAN:

Blady )	voland when	a lan	App otens		NO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO				
DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEA	ATH YES	NO UNCERTA						
25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Chec	k only one)						
1 VES 2 NO	HOSPITAL:		OTHER: 4   Nursing Home 5   Residence 6   Other (Specify)						
27. MANNER OF DEATN  1 Neturel 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW INJ	URY OCCURED				
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, street, fa	ctory, office	261. LOCATION (Street end City or Town, State)	d Number or Rural Route Number,				
	CIAN: To the best of my knowledge, do				er ea stated, due to the cause(e) and manner ee stated.				
296. SIGNATURE AND TITLE OF CENTRESS	( WILL		29c. LICENSE NO	JMBER :	29d. DATE SIGNED (Month, Day, Year)				
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)							
DAVID T. WALKE			VE AZOL	SAlichie	md, 2180)				
31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGNATURE								
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH MAY MCGEE RICHARD ALLEN 26 0525 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 F MIN. 212-56-9733 45 YRS. Maryland March 26, 1950 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Salisbury Wicomico 1 YES 2 KNO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 26932 Black Horse Run 21801 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ YES 2 🔀 NO Specify: BY 3 Widowed 4 Divorced Specify: Viet Nam White ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Clerk Social Security Admin. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) Ħ Glenn Allen McGee BE Ada Elizabeth Shorts notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26932 Black Horse Run, Salisbury, MD 21801 2 Catherine S. McGee must be 20e. METHOD OF DISPOSITION
1)C Buriel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Maryland Veterans Cemetery 5/30 Hurlock, MD examiner RE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 the medical Gys that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List grify Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) 30 Embolus ulmonary event. DUE TO (OR AS A CONSEQUENCE OF): Inumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST -PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FRIDBIOS Macro adenema. L. of Health and shows any i Hutun MAILABLE PRIOR TO COMPLETION OF CAUSE 1 HYES 2 ONO OF DEATHY 1 - YES 2 100 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TES 2 NO Inpetient 2 ER/Outpetient 3 DOM 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED marked. 1 Netural 2 Accident 5 Pending м 1 YES 2 NO BY Investigation 26e. PLACE OF INJURY — At hories, farm, street, factory, office building, etc. (Specify) 28 is 3 Suicide 28f. LOCATION (Street and Number or Rurel Route Number City or Seen, State) 6 Could not be COMPLETED 4 Homicide men 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HUSSPITAL OF TO THE FUNERAL DE Se fied within 72 ho MEDICAL EXAMINER: On the besix of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Movin, Cos) Visit)

► 5/27/95 BE Offnewlater 129105 0 30. NAME AND ADDITIONS OF COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Milhad St. SAlisbury Md. 21801

ChRISTSON

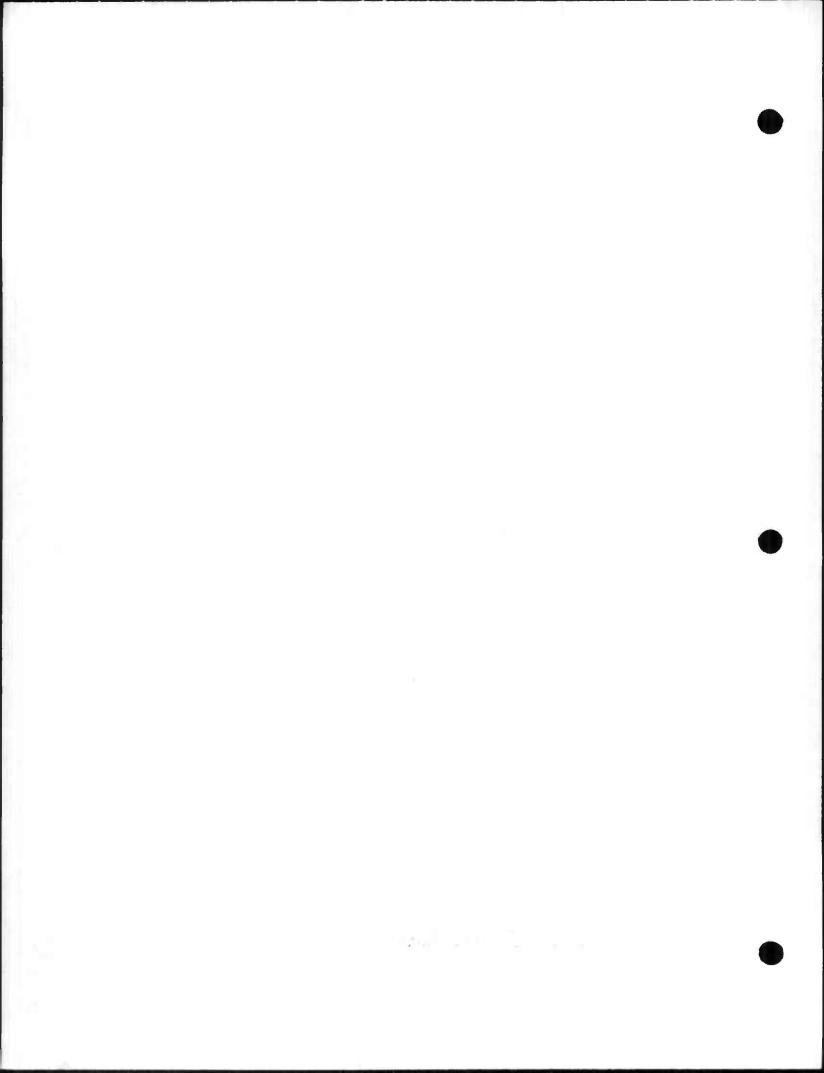
31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE
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page 5 should be detached for use as the bunial-transit retained by the hospital or attending physician, Page 6 may be r the funeral director, hours after death. filled in by t and completely fille burtal, cremation. death certificate be exert attending physician and ental Hygiene prior to b requires that the death the atten n signed by the Health and I been at. of t has be Dept. ( OR ATTENDING PHYSICIAN: The law r DIRECTOR: After this certificate has be hours after death with the State Dept. FUNERAL E within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT; I

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH
MONTH
JUNE 3. TIME OF DEATH Paul H. Milliken 9:201 995 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day Year) APTIL 20, IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 79 1 X M 2 - F DAYS HOURS 1916 De l'aware 218-40-0053 0953 YRS MIN. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1876 Old Field Point Road E1kton Cecil County RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY LIMITS? Maryland Cecil County E1kton 1 YES ZEX NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1876 Old Field Point Road 21921 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2XXNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 ND Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 XX Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Clive kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elemantary/Secondary (0-12) College (1-4 or 5+) 2 yrs. Farmer/Self-Employed Farming once. 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Malden Surname) H Carl Milliken BE Jane Green notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mabel R. Milliken 1876 Old Field Point Road, Elkton, Maryland 21921 å 20s. METHOO OF DISPOSITION
1 Disposition 3 Removal from State
4 Donetion 5 Other (Specify) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Ferris & Company 6/5/95 West Chester, PA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert T. Jones & Foard, Inc. 122 West Main St., Newark, DE
22 Page 1. Enter the diseases of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 122 West Main St., Newark, DE 19711 medicai Approximata interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition Multiple Cereby DUE TO (OR AS A CONSEQUENCE OF): Cerebrovas unlar Accidents resulting in death) event, Vears traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 any injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 TES 2 0 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \overline{\overl PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) the of 27. MANNER DF OEATH 28a. DATE DF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? marked, 26d, OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Accident Investigation 28e. PLACE DF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 69 COMPLETED 4 Homicide 28 met 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE DF GERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE rker a 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Northern Chesap cake

31. DATE FILED (Month, Day, Year)

1995

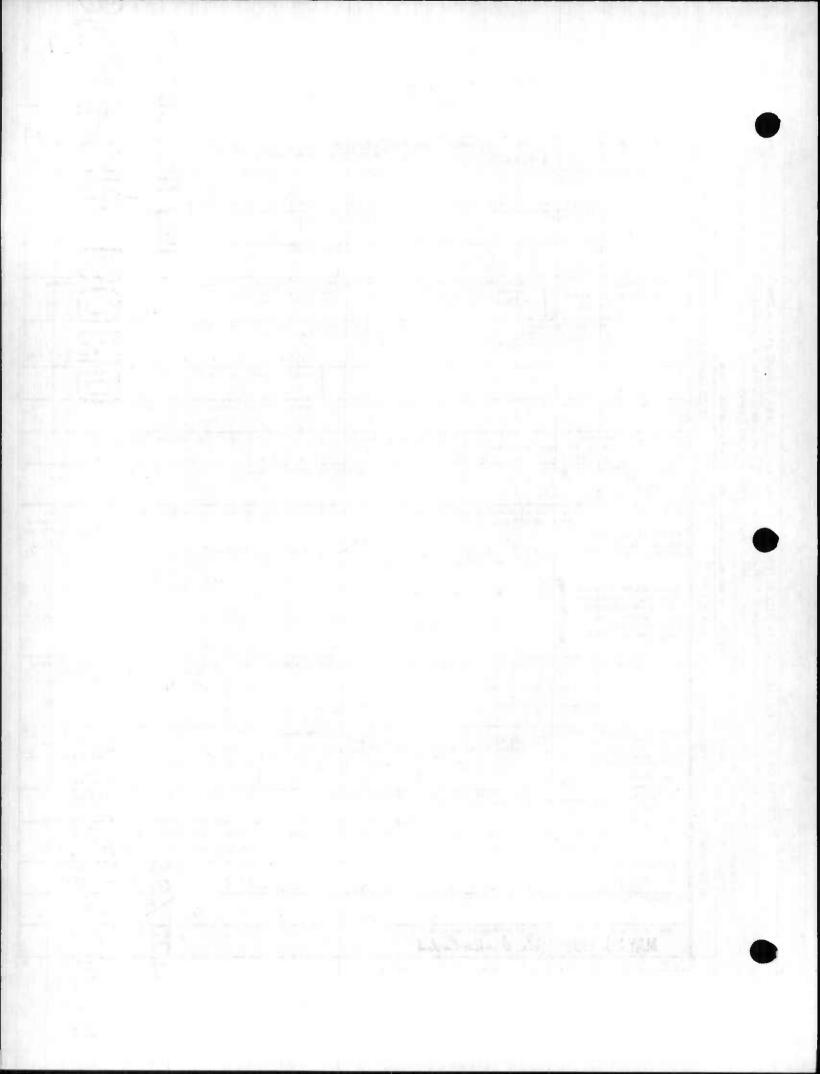
32. REGISTRAR'S SIGNATURE i Davidson Rardall

BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attanding physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If hem 28 is marked, or hem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT		3. TIME OF DEATH		
	Lola M. Mear	S		May 29	, 1995	DAY NEAD				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	T DATE OF BURE		BIRTHPLACE (State or Foreign		
	235-36-9803		70 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Yes	nr)	W. Virginia		
	9s. FACILITY NAME (If not institution, give	street and number)		96. CITY, TOWN C	R LOCATION OF D	EATH		Y OF DEATH		
DIRECTOR	121 Brown Stre	eet		E1:	kton		Ce	ecil		
S	10a. STATE 10b. COUNT	TY	10c. CITY	, TOWN OR LOCAT	ION			10d. INSIDE CITY		
	Md.	Cecil		Elkt	Elkton			LIMITS?		
FUNERAL	100. STREET AND NUMBER 121 Brown Stre	et		101	21921	41+3-1		S A		
3	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DEC						
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YE	S 2 X NO DATES		2 NO Specif	an, Puerto Rican, etc fy:	.)	4. RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	16a. DECEDENT'S (Give kind of w	USUAL OCCUPATION CONTROL OCCUPAT	DN st of working	16b. KIND OI	F BUSINESS/INDUS	STRY		
IPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		nance 1		W. 1	L. Gore	Associates		
Ö	17. FATHER'S NAME (First, Middle, Last)			777	18. MOTHER'S NA	AME (First, Middle, Ma	siden Surname)			
BE	B. J. Thomas				Katti	e Adda:	ir			
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City o				
-	Rita Alexander					Elkton				
	20e, METHOD OF DISPOSITION 1		ob. PLACE AND DATE of amelery, cremetory of of 11pin M	prosposition (Na her place) anor Me	me of ⊇m. Pk.	6/2 I	Elkton,			
	21. SIGNATURE OF UNITAL SERVICE L	CENSER		22. NAME AN	D ADDRESS OF FA	CILITY '	250 E	Main St., Md. 21921		
	23 DART I Enter the discuss of	44	and the death. Do a							
	23. PART I. Enter the dispases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final									
	disease or condition resulting in death)  a. Cancer of the pancre as  I month									
z		b	A SONGE GOLDE DE	, /						
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF	7):		11/2				
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	<b>ງ</b> :						
CER	Toodaing in deadily Exist	d								
	PART ii. Other algnificant condition	na contributing to death	but not resulting i	n the underlying	cause given in	Part i. 24s. WA	S AN AUTOPSY REORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
DICAL							ES 2 NO	COMPLETION OF CAUSE OF DEATH?		
Σ								1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				105.05.05.05.111.101					
SC	EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (C)	100 1100				
. ×	27. MANNER OF DEATH	1 Inputient 2 ER/O				6 Other (Specify	OW INJURY OCCU	DED		
ву Р	1 Netural 5 Pending 2 Accident Investigation	(Morith, Day, Year	) INJ	URY WO	RK?	Zou. DESCRIBE N	OW INJUNY OCCU	HED		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJU building, etc. (S)	RY — Al home, farm, e pecify)	treet, factory, offic		281. LOCATION (S City or Town,	treet and Number or State)	Rural Route Number,		
Suicide 4   Homicide 4   Homicide  29a. CERTIFIER (Check only one) 2   MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the								1////		
BE C	296. SIGNATURE AND TITLE OF CERTIFIC	ER O O	20	11 8	29c. LICENSE NU	MBER	29d. DATE S	SIGNED (Month, Day, Year)		
TO B	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALLES OF	ve //	10	D22	813	1 5	5/31/95		
	Patricia A.	Grevem M.	.D. 111	W. High	n St.,	Elkton	, Md.	21921		
	MAY 3 1 1995	Julia dhudson								
1	WIII 0 - 1000	Just an amader a	-4040-4					THE RESERVE AND ADDRESS OF THE PARTY OF THE		

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physician.	/ filled in by the funeral director, page 5 should be detached for use as the burial-transit p		
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death. Page 6 may be ret	funera		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										95	18	3598
	1 - STATE REGISTRAR	STATE OF N	MARYLAND /				EALTH AND DEATH	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)  Margaret  4. SOCIAL SECURITY NUMBER	A.	Miller	r				Ma	E OF OEATH DO		YEAR	9. 10
	213-48-4325	1 🗆 M 2XXF	8. AGE (In yrs. last	YRS.	MONTHS 1	DAYS	HOURS MIN.	(Mor	E OF BIRTH oth, Day, Year) 1.20,1	897	Country)	ACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give NATIONAL LUTH		ME				LOCATION OF	DEATH		4	TGOM	MERY CO.
DIRECTOR	MD . MONT	10c. CIT	Y, TOWN OR		SPRIN	G			1.0	Od. INSIDE CITY LIMITS?  X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 1519 - DAI	E DRIVE				101.	ZIP CODE 2091	0				AT COUNTRY?
В	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES					13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.)  1  YES 2 No Specify:  Specify: WH ]					White, etc.	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 1 2	(Gi life.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  HOMEMAKER  AT HOME									
BE CON	17. FATHER'S NAME (First, Middle, Last) WILLIAM W.	DALY					18. MOTHER'S N		Middle, Maiden	Sumame) (DAL	Y)	65
0	19a. INFORMANT'S NAME (Type/Print) WILLIAM W. MI	LLER	19th B(	X Z	ADDRESS (S	Street an	Number or Rura	STOW	N, PA.	1, State, Zip		
	20s. METHOD OF DISPOSITION  **Purial 2   Cremation 3   Ren 4   Donation 5   Other (Specify)	ND DATE O	of disposition of the place)		e of SETERY	5/3		SHTN		, Stets		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND AD HYSON							ACILITY IN			-	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdie shock, or heart fellure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  PNEW MONIA  DUE TO (OR AS A CONSEQUENCE OF):							rdiec or reapi	ratory arre	eat,	Approximate interval Between Onset and Death 2 DAGS	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST											
PHYSICIAN: MEDICAL CE	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  Congestive Heart Ta ( w.e.								24a. WAS AN PERFOR 1 YES 2	MED?	CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?  YES 2 NO
AN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA			S NO		UNCERTA	IN 🗆				_ 160 2 _ 100
SICI	EXAMINER?  1 YES 2 X NO	HOSPITAL:			OTHER:		5 Residence	6 Dth	er (Specify)			
F	27. MANNER OF DEATH	28a. DATE OF (Month, De		28b, TIM		Bc. INJU WOR	RY AT	_	SCRIBE HOW IN	JURY OCC	URED	

1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)

281, LOCATION (Street and Number or Rural Route Number City or Town, State)

29c. LICENSE NUMBER 3 1 3 8 29d. DATE SIGNED (Morith, Day, Year)

\$\int S - 28 - 95\$

ass MSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PV 12850 Widdleby Be Daniel

Germantown ebrook

wo 20874

8 Could not be determined

L- Natural

2 Accident

3 Sulcide

4 Homicide

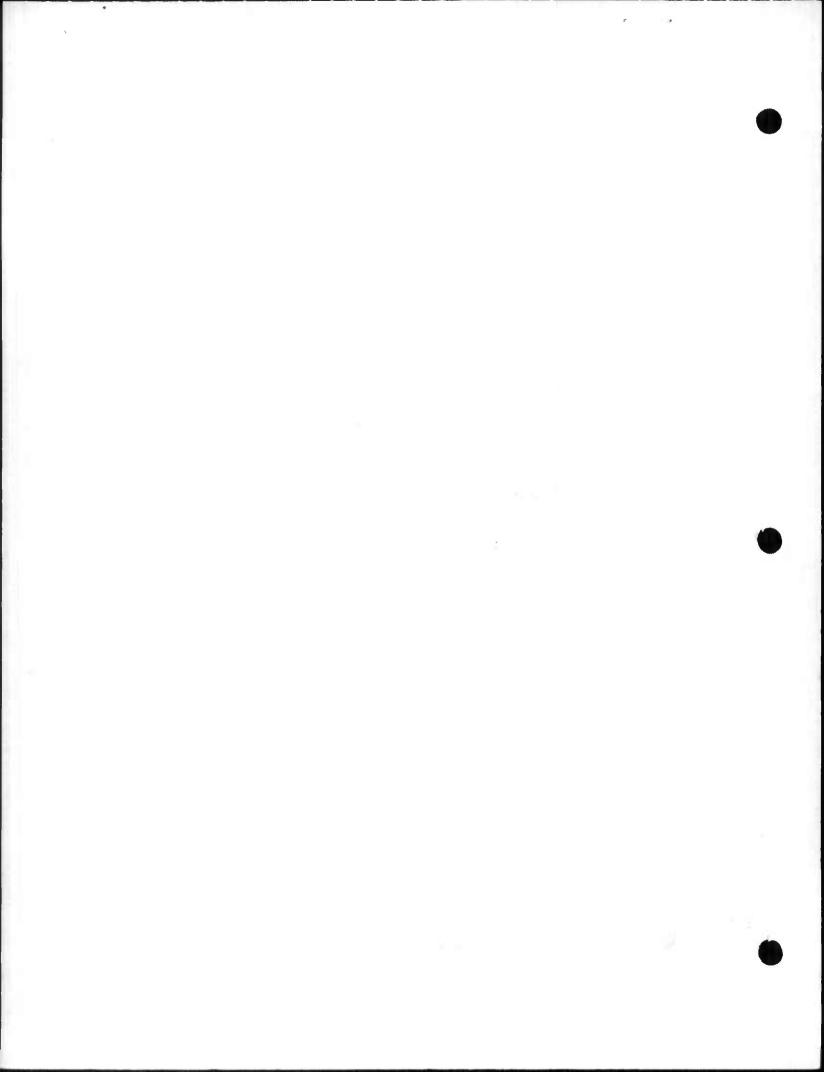
BY

TO BE COMPLETED

(P)

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



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296. SIGNATURE AND TITLE OF CERTIFIED

ELIAS G. DEBBAS

31. DATE FILED (Month, Day, Year) **JUN** 01 1995

BE

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attending physician.	use as the burial-transit permit. Pages 1		,
within a hours after death. Page 6 may be retained by the hospital or atte	neral director, page 5 should be detached for		miner must be notified at once.
artificate be executed within a hours after deal	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burish-transit permit. Pages is	he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
YSICIAN: The law requires that the death certificate be executed with	s certificate has been signed by the attendi	th the State Dept. of Health and Mental Hy	id, or item 23 shows any injury, or
THE HOSPITAL OR ATTENDING PHY	THE FUNERAL DIRECTOR: After this	he filed within 72 hours after death with	MPORTANT: It item 28 is marke

95 18599 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DEBBILENE MIFFLETON MAY 25 1995 7:50 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1 M 2 F DAYS HOURS MIN. YRS 215-68-8103 40 Jan.7, 1955 Cheverly, MD 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FORT WASHINGTON MEDICAL CENTER Fort Washington Prince Georges RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince Georges Oxon Hill 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2130 Alice Avenue 20745 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicon, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Shan kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (full or 5 4) 9th Never Worked n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roy E. Miffleton BE Dorothy J. Lambert 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 8002 Carey Branch Dr. Ft. Washington. MD 20744 Raoma Keys 20a. METHOD OF DISPOSITION
1 Burlel 2 S Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 8 Other (Specify) Metropolitan Crematory 5/30 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746 23. PARTY. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdisc or respiratory arrest, Approximate ahock, or heert failure. List only one ceuse on each line. nterval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition HEPATIC FAILURE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) LIVER METASTASES CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CARCINOMA OF CERVIX DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in death) LAST PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE I YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO MUNCERTAIN 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 TES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be datermined 4 Homicide 29a, CERTIFIER 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner es atated. 2 MEDICAL EXAMINER: On the beels of examin ition and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D19347

11701 LIVINGSTON RD #201 ft. washington, md 29744

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

►MAY 26, 1995

Amended # 4, P.G., GC, 0/2/95

95 18600

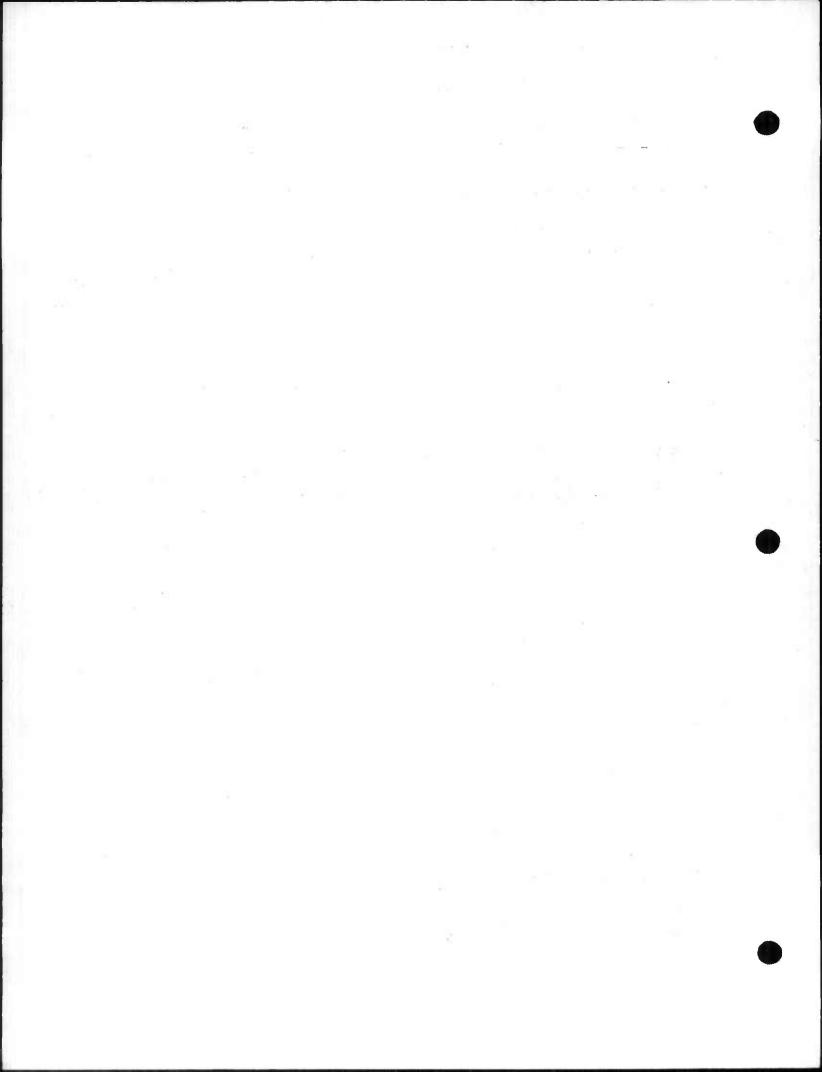
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 her forms and fraction by the intensity of the standard of the standa

**BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68769

ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/5/95 t.t
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND	/ DEPAR	RTMENT	OF H		MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								E OF DEATH	<u>.                                    </u>	T	3. TIME OF DEATH
	Timothy	Patrick		ľ	Mora	n		May	7 24	19	95	1920 M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. I	last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH		8. BIRTH	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give a	atreet and number)			9b. CITY,	TOWN O	R LOCATION OF E		,		NTY OF DI	
DIRECTOR	Anne Arundel Ge	eneral Ho	spita	al			polis					rundel
H	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY LIMITS?
		e George's	3	Col	lege	Par	k					1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER						ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
ÿ	5802 Chestnut Hi						20740			U.S.	.A.	
BY FU	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT ET FORCES? 1 I	YES 2		10	yes, spe	ENDENT OF HISPA city Cuban, Mexic 2 X NO Spec	/ Cuban, Mexican, Puerto Rican, etc.)  RIO Specify:  Specify:				V:
		<u> </u>					- 10					White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)		Give kind of	work done d			16	b. KIND OF BU	SINESS/IND	USTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5 +)	1	lle. Do NOT u								
<u>×</u>	17. FATHER'S NAME (First, Middle, Last)	4	C	ontra	ctor				Self-En		ed	
	Charles B. Moran						Hazel H			Sumame)		
B	19a. INFORMANT'S NAME (Type/Print)					100	nazel I					
임	Hazel B. Moran											D 20740
	20a. METHOD OF DISPOSITION			EANDDATE								
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetery, c	rematory or o	ther place!	,		20 /0		CATION —	-	
	21. SIGNATURE OF FUNERAL SERVICE LIC		Juanva	ary Ce	22. 1	AME AN	D ADDRESS OF F	30/9				Pennsylvania
	M. B.G.	essa			Fr	anc	is Gasch	i's S				ne, P.A.
	23. PART I. Enter the diseases, or cahock, or heart failure.	complications that cr	used the d	leath. Do r	not enter	the mod	te of dying, au	ch aa ca	rdlec or reap	Iratory arr	eat,	Approximate
- (),	IMMEDIATE CAUSE /Final	List Only Ona Cause	on each iir	16.								Interval Between Onset and Death
	disease or condition a. CARDIAC ARRHYTHMIA											
	DUE TO (OR AS A CONSEQUENCE OF):											
z	Sequentially list conditions,											
CERTIFICATION	If any, leading to immediate											
2	CAUSE (Disease or Injury											
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
	d											
AL.	PART II. Other algolificant condition	a contributing to de	eth but not	resulting	in the und	derlying	cause given in	Part I.	24e. WAS AN		24b.	WERE AUTOPSY FINDINGS
ğ									1 YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
빌					-			_	1			OF DEATH?  1 YES 2 NO
z I	DID TOBACCO USE CONTI	RIBUTE TO CAUS	E OF DE	ATH YE	S 🗆 N	10 🗆	UNCERTAI	N□	ĺ			
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL/	CE OF DEAT								
Š	LA YES 2 NO	HOSPITAL: Y	t/Outpatient	3 DOA	OTHER		5 Residence	8 Oth	er (Specify)			
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28a. DATE OF INJ (Month, Day, Y	URY	28b, TIM	E OF URY	28c. INJU WOR		28d. DE	SCRIBE HOW I	NJURY OCC	URED	
<u> </u>	1 Neturel 5 Pending (Month, Day, Year) 2 Accident Investigation				М		ES 2 NO					
	3 Suicide B Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LO						BI. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the beat of my	knowled	lanth c	4 4 6 . 0	1135		CHOC -				
COMPLETED	(Check only one) 2 MEDICAL EXAMINE	R: On the basis of exami	ination and/or	r Investigatio	n, in my op	ne, date a pinion, de	and place, and durath occured at the	time, dat	e and place, an	nner as atate	ed. e cause(a)	and manner as stated.
BE	296. SIGNATURE AND TIBLE OF CERTIFIER 29d. DAT							29d. DATE	SIGNED	Month, Day, Year)		
2	I Medpre 16.	Kings .	ars				O.C.M	Ε.				6 1995
ř	30. NAME AND ADDRESS OF PERSON WHO		F DEATH (IT	ЕМ 27) (Туре,	Print)							
	31 DATE FILED (Month, Day, Year)			11 Pá	enn (	Str	eet, Ba	alti	more,	Mar	yla	nd 21201
	MAY 31 1995 Jul	hi Dandler K	ardall									



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.

MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG. NO	),			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
1 8	ROSE	MAE		N	IONROE	MAY 26	199	YEAR 11.00D M		
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH		5 11:00P M B. BIRTHPLACE (State or Foreign		
	577-40-4650	1 □ M 2 X F	65 YRS.	MONTHS DAY		JAN . 8, 1		Country)		
1 0	9a. FACILITY NAME (If not institution, give s	1 1111111111111111111111111111111111111	0.5					SUMMERTON, SC		
OC.				96. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUNT	TY OF DEATH		
2	75 EAST WAYNE	AVE.		SILV	ER SPRIN	NG	MON'	TGOMERY		
DIRECTOR	10a, STATE 10b, COUNT	γ	10c CI	Y, TOWN OR LO	CATION					
<u>E</u>	MARYLAND MON	TGOMERY			SPRING			10d. INSIDE CITY		
	10e. STREET AND NUMBER	TOOTERT		TTARK				1 X YES 2 NO		
N.	106. STREET AND NOMBER				10f. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?		
買	75 EAST WAYNE	AVENUE, #V	V-112		20901		U	·S·A·		
FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS I	DECENDENT OF HISPA , specify Cuban, Maxic	NIC ORIGIN? (Specify Ye	e or No-	14. RACE — American indian, Black, White, atc.		
BY	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR			rES 2 NO Specif			Specific		
EDE		<u> </u>						BLACK		
1	15, DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of	work done during	ATION most of working	16b. KIND OF BU	SINESS/INDU	ISTRY		
2	Elementary/Secondary (0-12) 9th	College (1-4 or 5+)	ANIMAL		AVED					
MP			HINTIMAL	CAREI	AKEK	IN	IH			
COMPLET	17. FATHER'S NAME (First, Middle, Lest)					ME (First, Middle, Meider	Sumame)			
H	MOSES	ELIJAH		INNEY	ANNII			LOVER		
6	19a. INFORMANT'S NAME (Type/Print)	CATT				Route Number, City or Tox				
-	MARYLAND M.	CAUL	75 E.	WAYN	E AVE.,	SILVER S	PRIN	G, MD 20901		
	20e. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Ram	oval from State	b. PLACE AND DATE metery, crematory or c	OF DISPOSITION	(Name of	DATE 20c. L.C	CATION - CI	Ity or Town, State		
	4 Donation 5 Other (Specify)	B	ARMONY	MEMOR	IAL PARE	2-95LAN	DOVE	R, MD		
	21. SIONATURE OF FUNERAL SERVICE LI	ENSEE O	///	7 22, NAME	ANO ADDRESS OF FA	CILITY				
	* loke Ald	Minb	Va cl				HOME			
	23. PART I. Enter the diseasea, or	complications that cause	od the death. Do	1/Z	Z NURTH	CAPITOL	ST.,	NW WASH.DC		
	shock, or heart failure.	List only one ceuse on	each line.	not anter the	mode or dying, add	in all cerdiec or reap	iratory arre	at, Approximata Interval Between		
	IMMEDIATE CAUSE (Finel disease or condition			1		1 . 1		Onset and Death		
	resulting in death)									
1 1	OUE TO (OR AS A CONSEQUENCE OF):									
ᄝ	Sequentially list conditions,  OUE TO (OR AS A CONSEQUENCE OF):									
۱ĕ۱	If any, leeding to immediate	OUE TO (OR AS	A CONSEQUENCE O	F):						
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	c								
ᄩ	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	<b>F</b> );						
CERTIFICATION	Tooding in dozin) EAST	d								
	PART II. Other algnificant condition	e contributing to death	but not resulting	In the underly	ing cause given in	Part I. 24s, WAS AN	AUTOPEV	24b. WERE AUTOPSY FINDINGS		
DICAL					g vance given in	PERFO	RMEO?	AWAILABLE PRIOR TO COMPLETION OF CAUSE		
						1 XYES :	NO NO	OF DEATH?		
ME	DID TORA COO LICE ACT -	NIDITE TO CALLE				i		1 NYES 2 NO		
PHYSICIAN:		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:	ne)					
YS.	1 TYES 2 NO	1   Inpetient 2   ER/Out	patient 3 DOA		lome 5 Residence	6 Other (Specify)				
표	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	JURY	INJURY AT WORK?	28d. DEŞCRIBE HOW	NJURY OCCU	PRED		
A	2 Accident Investigation				YES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, tarm,	streat, factory, o	ffica	28f. LOCATION (Street City or Town State)		r Rural Route Number,		
COMPLETED	4 Homicide determined City or Town, State)									
1 2	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my know	viedge, death occurr	ed at the time, d	lete and place, and due	to the cause(a) and ma	nner as stated	1,		
M								cause(s) and manner as stated,		
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI					
H		M			O.C.			StGNED (Month, Day, Year)		
2	30. NAME AND POSESS OF PERSON WH	O COMPLETED CAUSE OF T	EATH ATEN AT	0	0.0.	M.E.	MAY	27, 1995		
	Al Don				m	WORE	D	ID 01001		
	31. DATE FILED (Month, Day, Year)			SIKEE	I, BALTI	MORE, MA	KYLAN	ND 21201.		
	MINI 01 1005	32. REGISTRAR'S SIGN								
		44 4 TAX - 27 TO F TAX DESCRIPTION OF THE PARTY AND ADDRESS OF THE PART	arrest of Auto							

. . Talk giller inst 

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE C	F DEATH		RE	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2	DATE OF DE				3. TIME OF DEATH	
	BILLY	MCMILLA	N			N	MONTH MAY	19	19	YEAR Q5	4:45	a M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 I		DATE OF BIE				PLACE (State or Foreign	
	579-90-1340	1. M 2 □ F	35 YRS.	MONTHS DA	TE HOURS N	m.	(Month, Day,		- 1	Country	th Caroli	
	9e. FACILITY NAME (If not institution, give atr			Sh CITY TON	VN OR LOCATION					TY OF DE		na
œ			1			OF DEATH						
DIRECTOR	WASHINGTON ADVENT	LIST HOSPI	IAL	TAKOMA PARK MONTGOMERY								
E C	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO	CATION						10d, INSIDE CITY	
<b>5</b>	MARYLAND P. GEO	DRCFS	רעענו	TSVIL	TE						LIMITS?	
	10e. STREET AND NUMBER	MOLD	IIIAI	ISVIL	101. ZIP CODE			L	A. OITIT	EN OF W	1XXYES 2 NO	,
BY FUNERAL	6405 Medwick Drive											
W	11. MARITAL STATUS	12. WAS DECEDENT EVE	=		20783						States	
교	Nover Married 2 Married	FORCES? 1 Y	ES 2 NO	13. WAS	DECENDENT OF H , specify Cuban, N	IISPANIC Iexican, P	ORIGIN? (Spe Puerto Rican, o	cify Yes or Mc.)	No-	14. RACE Black	- American Indian, White, etc.	
à	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES	1 🗆	YES 2 NYO	Specify:				Specif	y:	
	15. DECEDENT'S EDUC	ATION	te- processivia				T	23 00000	1	Blac	2K	
=	(Specify only highest grade of	completed)	(Give kind of wo	ork done during	TATION Transit of working		16b, KIND	OF BUSINE	SS/INDU	ISTRY		
ן ב	Elementary/Secondary (0-12)	College (1-4 or 6+)										
불	12th		Truck Dr	iver				ate :		stry	7	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	'S NAME	(First, Middle,	Maiden Sun	name)			
BE	Willie Ritter				Thoma	sen	a M. M	cMil:	lian			
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	et and Number or I	Rural Rout	te Number, City	or Town, S	tate, Zip (	Code)		
F	Thomasena Hodges,	Mother	6405 M	[edwic]	k Drive.	Hya	attsvi	lle.	Mar	vlar	nd 20783	
	20s. METHOD OF DISPOSITION		20b. PLACE AND DATE OF	DISPOSITION			DATE					
	1 Buriel 2 Cremation 3 Remo	val from State	cemetery, crematory or oth Church Cen	er place)	23 May	7 95		Allei	nda1		s C	
	21. BIGHATUNE OF FUNERAL BERVICE LICE	HIEE			E AND ADDRESS			n s	Ionk	inc	Tno.	
	N/ / //	1, 1										
	ful D	Junt		- 1	Kennedy						20011	
	23. PART. Enter the diseases, or co shock, or heart feliure. L	inplications that cau	sed the death. Do no	t enter the	mode of dying,	such a	a cardiac o	reapirate	ory arre	at,	Approximate	
	IMMEDIATE CAUSE (Final	ist only one cause o									Interval Betw Onset and D	
	disease or condition	LOGIM	11 cotis	P	Reim	mic	a B	illow	0		1992	4401
	resulting in death)	DUE TO (OR A	U CY STIS			(		rusico	4		1116	
		DED.	and True		Reim . defic	0.	<		44 . 0			
6	Sequentially list conditions, b.	DITECTO (OR A	S A CONSEQUENCE OF)	nance	. capie	June 1	7	nea				
F	If any, leading to immediate cause. Enter UNDERLYING	2020.0 (0	a n dondedende or )	•			0					
ERTIFICATION	CAUSE (Disease or injury	DIJE TO (OR 4	S A CONSEQUENCE OF)									
	that initiated events resulting in death) LAST	502 10 (011 )	o A CONSCIOENCE OF								i	
	d.											
	PART ii. Other algnificant conditions	contributing to deat	h but not resulting in	the underi	ying cause give	n in Par	rt I. 24a. V	MAS AN AUT	TOPSY	24b	WERE AUTOPSY FINDS	NGS
SA	none						, F	ERFORME	07		AVAILABLE PRIOR TO COMPLETION OF CAUS	
							-   1 🗆	YES 2	MO		OF DEATH?	
M	DID TODA 660 UST 601 TO				_/_		_				1 TYES 2 TINO	
ž	DID TOBACCO USE CONTR	IBUTE TO CAUSE				TAIN						
<u> </u>	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)  EXAMINER? OTHER:											
PHYSICIAN:	1 TYES 2 TATO	1 npetient 2 ER/C			iome 5 🗆 Reside	ence 6	Other (Speci	thy)				
Ŧ	27. MANNER OF DEATH	26a. DATE OF INJU! (Month, Day, Yes		OF 28c.	INJURY AT WORK?	28	d. DESCRIBE	HOW INJU	RY OCCL	IRED		
- 1	1 Natural 5 Pending 2 Accident Investigation		, , , ,		YES 2 N	0						
9	3 Suicide 8 Could not be	28s. PLACE OF INJ	JRY - At home, farm, str	eet, factory, o	office	20	H. LOCATION	Street and i	Number o	r Rural Ro	oute Number,	$\neg$
LED	4 Homicide determined	building, etc. (S	Бреспу)				City or Town	, State)				
4	29a. CERTIFIER	IAM TO A	The same of the same of									
COMPLE	(Check only											. 1
3	2 MEDICAL EXAMINER	: Un the besis of examina	ntion and/or investigation	, in my opinio	n, death occured a	t the time	e, data and pi	aca, and du	a to the	cause(a)	and manner as state	d.
n n	#85. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSI	E NUMBE	R	29	d. DATE	SIGNED	(Month, Day, Year)	
	Whows Ham				1014	140	54/		5	19.	-95	
2	36. NAME AND ADDITION OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, F	Print)						- 1	1-	
	Charles ) Frank(1)		11120 mer	Ultim	105/1100	Kh.	5	her	So.	1411	mo ZoGNI	
	21. DATE FILED (Month, Day, Year)	32, REGISTRAR'S S	IGNATURE.	- i wh	pouline	IXU		. = 4-1	per	my.	10/01	
	MAY 31 1995	Jahra Dave	sor-Randall									
	1000	17										

be retained by the hospital or attending physician. ge 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS DO BOY 68750

ָהָרְאָרָה, הַרְאָרָה,	e 6 may b	rector, pag	
DAL IMORE,	rs after death. Pag	by the funeral d	removar.
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may b	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	be med writin /2 hours driet beaut with the state bept. Of health and mental hyghere prior to build, cremation, of removal.
	10	5	3

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last	)			2. DATE OF DEATH DA	3.	TIME OF DEATH				
	Anne		Marshall		June 2		4:05 A M				
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTNPLA	CE (State or Foreign				
	212-32-2847	1 □ M 2 🔀 F 7	7 YRS.		Sept 4 19		sylvania				
( c	9e. FACILITY NAME (If not institution, give			CITY, TOWN OR LOCATION OF DE	EATN	9c. COUNTY OF DEATH	4				
RECTOR	Meridian Health Care Center/Spa Creek Annapolis Anne Arund										
E S	10a. STATE 10b. COUNT	TY	10c. CITY, TO	OWN OR LOCATION		100	I. INSIDE CITY				
E	N .	e Arundel		Annapolis		1.5	LIMITS?				
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF WHAT					
Ä	203 Kirkley Ro	oad		2	1401	United S	States				
FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF NISPAN	HC ORIGIN? (Specify Yes	or No- 14. RACE - A Black, Wh	American Indian,				
B	1 Never Married 2 Married  3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	If yes, specify Cuban, Mexica 1 YES 2 NO Specify		Specify:					
م ا	15. DECEDENT'S ED	UCATION	16a. DECEDENT'S USE	IAL OCCUPATION	Tan mus as an		White				
ETE	(Specify only highest grad		(Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUS	INESS/INDUSTRY					
1	Little Harry Controlly (0-12)	2	Vice Pre	sident	Plumbir	ng Contract	rore				
once.	17. FATHER'S NAME (First, Middle, Last)		V100 110		ME (First, Middle, Maiden 3		.013				
M M	Jacob Kowalc	zk		Anı	na Procak						
TO B	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING AD	DRESS (Street and Number or Rural I		n, State, Zip Code)					
5 -	JoAnne M. Weddle	9	1 Oak	Drive Annapolis	Maryland	21401	171				
examiner must be notified	20g. METNOD OF DISPOSITION  1 Duriel 2 Cremation 3 Man		. PLACE AND DATE OF D	ISPOSITION (Name of		CATION — City or Town, S	State				
E	4 Donation 6 Other (Special 21. SIGNETURE OF FUNERAL SERVICE)	S	t. Margare	ts Cemetery 6/	6/95 An	napolis. Ma	ryland				
Ē		CENSEE		22. NAME AND ADDRESS OF FA	John M.	Taylor Fun	eral Home				
ex _	J. J. DARK ACA	W.		147 Duke of (			is, MD				
medical	23. PART I. Enter the diseases, or shock, or heart failure	somplications that caused. List only one cause on e	the death. Do not	enter the mode of dying, such	h as cardiec or reapir	ratory arrest,	Approximata				
	IMMEDIATE CAUSE (Final	and only one deade on a		n Care		j	Intervel Between Onset and Death				
#	disease or condition resulting in death)	a	1100	Care	und		6 Ma				
94	DUE TO (OR AS a CONSEQUENCE OF):										
or other traumatic event, the	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):										
AT	if any, leading to immediate cause. Enter UNDERLYING										
other TIFI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			<u>_</u>					
9 111	resulting in death) LAST	d									
Injury, o	PART ii. Other significant condition	ns-contributing to death h	ut not resulting in th	an underfulne course share le	Don't las una su						
- 1 - 2	HASCU		71.73	ie underlying ceuse given in	Part I. 24s. WAS AN A PERFORE	MED? AMAI	LABLE PRIOR TO				
shows any : MEDIC		1 100			1 TYES 2)		IPLETION OF CAUSE DEATH?				
sho ::	DID TOBACCO USE CONT	PIRLITE TO CAUSE O	E DEATH VEC	□ NO □ UNCERTAIN		1 🗆	YES 2 NO				
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (C		1 4						
sici/	EXAMINER?	HOSPITAL: 1   Inpatient 2   ER/Outp		HER: (ursing Home 5 - Residence	8 C Other (Specific)						
od, or	27. MANNER OF DEATH	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW IN	JURY OCCURED					
marked, BY PH	1 Ratural 5 Pending 2 Accident Investigation	(MOINI, Day, Hear)	INJURY	M 1 YES 2 NO							
<u>∞</u> 0	3 Suicide 6 Could not be	28a. PLACE OF INJURY building, etc. (Spec	— Al home, farm, stree	261. LOCATION (Street ar City or Town, State)	nd Number or Rural Route	Number,					
m 28 ETE	4 Homicide determined		·		City of Town, State)						
흳	29a. CERTIFIER CERTIFYING PHYS	ICIAN: To the best of my knowl	edge, death occurred at	the time, data and place, and due	to the cause(s) and mann	ner as stated.					
N N	one) 2 MEDICAL EXAMIN	ER: On the basis of examination	and/or investigation, in	my opinion, death occured at the	lime, data and place, and	i due to the cause(a) and	manner as stated.				
를 때	296 SIGNATURE AND TITLE OF CERTIFIE		1.4	29c. LICENSE NUM	IBER	29d. DATE SIGNED (Mon	th, Day, Year)				
TO B	1000	· Own	V	D2143	8	▶ June 2,	1995				
=	30. NAME AND ADDRESS OF PERSON WI										
	Wichael J. La	Penta, M.D.	600 Ridgle	ey Avenue Anna	polis, MD 2	21401 (410-2	224-0070)				
	31, DATE FILED (Month, Day, Year) JUN 08 1995	32. REGISTRAR'S SIGNI	TURE								
	3011 0 6 1333	July almande	variable								

ned attack

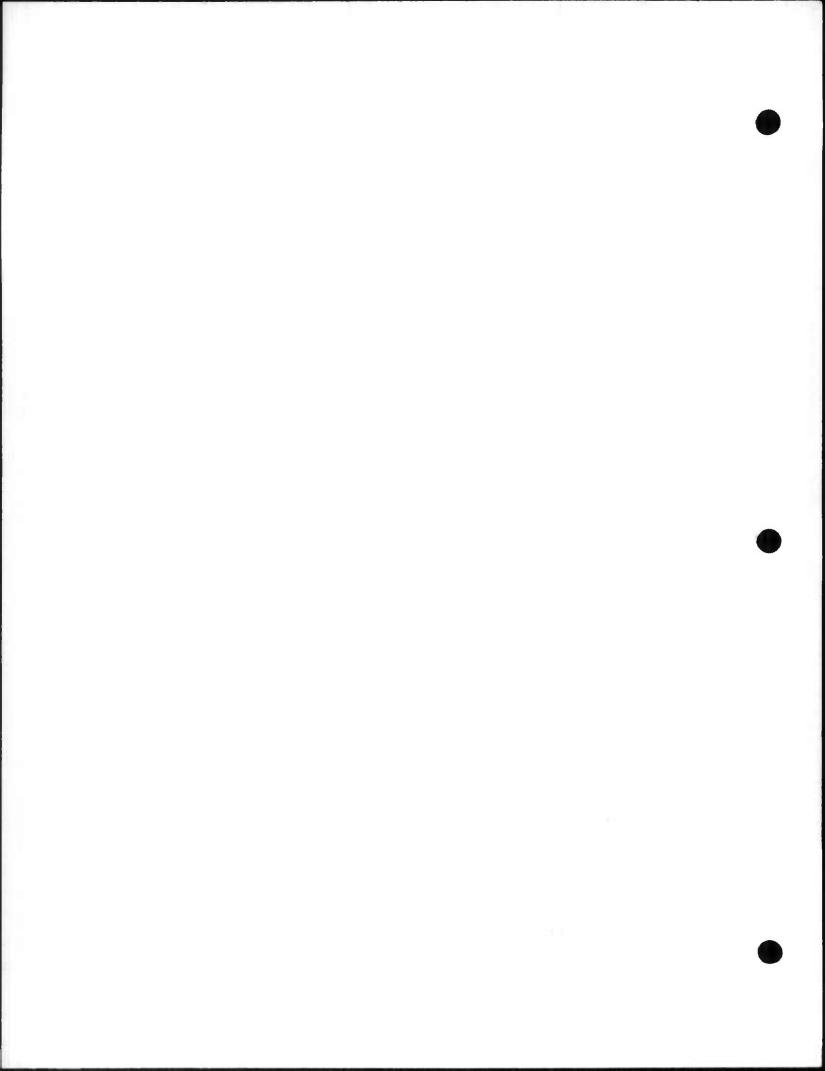
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—" hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	FORREST		L.			M	ILLE	IR		May 22, 19	95	YEAR	10:50 P
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. Is	st birthday)	IF UNDE	1 YEAR	IF UNDER	24 HRS.	7, DATE OF BIRTH 8. BIR			IPLACE (State or Foreign
	214-16-257.		1 🔀 M 2 🗌 F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) Apr 14,	910	Count	(1/1)
	9a. FACILITY NAME (If not institution, give street and number)							OR LOCATI			-	NTY OF D	
DIRECTOR	Memorial Hospital & Medical Cente				er	Cumberland Allegany					ny		
EG	RESIDENCE OF DECEDENT  10a, STATE 10b, COUNTY				10c CIT	Y, TOWN	OR LOCA	TION					
H	WV	Min	eral			Keys		ION					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			<u>-</u> -		rey o	-	I. ZIP COD	E		10a, CITI	ZEN OF Y	1 YES 2 NO
FUNERAL	Rt 4 Box 120							26	726			.S.A	
S	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT C	F HISPAN	IIC ORIGIN? (Specify Yas		14 BACE	F American Indian
BY F		1 Never Married 2 Married FORCES? 1 Never Married 3 Widowed 4 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			NO		It yea, ap	ecify Cuba 2 X NO	n, Maxicai Specify	n, Puerto Rican, etc.)		Speci	k, White, etc.
	7811 -	-		I									White
COMPLETED	(Specify onl	EDENT'S EDUC y highest grade	CATION completed)	(0	ECEDENT'S	work done	during mo	ON ast of worldr	g	16b. KIND OF BU	SINESS/IND	DUSTRY	
ا ۳	Elementary/Secondary (t	)-12)	College (1-4 or 5	+)	n <i>Do NOT u</i> arman					Railr	o o d		
8	17. FATHER'S NAME (First, M	Holdle, Last)		1 00	A L MCCII			10 1407	IEO'O NA	ME (First, Middle, Maiden			
Ö	W. Newton		ler						arah	Jane	Smi	th	
0	19a. INFORMANT'S NAME (7	ype/Print)		11	b. MAILING	ADDRES	S (Street a			Route Number, City or Tow			
2	Alan R. Mil:	ler						Dri		Charlesto			25311
	20a METHOD OF DISPOSIT	ION	oval from State	20b. PLACE	AND DATE	OF DISPOS	SITION (No	me of		DATE 20c. LO	CATION —	City or To	wn, State
	4 Donation 5 Other	(Specify)		Que e	ns Po	ing place)	Ceme	etery	5/25	/95 Ke	yser,	WV	26726
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENGER					ADDRES		Funeral H	omo.		
		en K	ette	. V		8.5	Son	ith M	lain	Street K	evser	. WV	7 26726
$\neg$	23. PART I. Eriter the di	and fallure I	omplications the	t caused the d	eeth. Do i	not enter	the mo	de of dyl	ng, such	aa cardlac or reapi	ratory arr	reat,	Approximata
ĺ	IMMEDIATE CAUSE (Final										Interval Batween Onset and Death		
	disease or condition resulting in death)	<b>→</b> ,	RESPIRA	TORY FA	LURE								6 HOURS
		DUE TO (OR AS A CONSEQUENCE OF): PNEUMOTHORAX S/P PLEURODESIS									4 DAYS		
S O	Sequentially list conditions,									4 DAID			
Ž	cause. Enter UNDERLYING INTERSTITIAL LUNG DISEASE								4 YEARS				
드	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUEN						NCE OF):						
CERTIFICATION	resulting in death) LAS	T (	COR PULI	MONALE							2 YEARS		
- 11	PART II. Other algolifica	nt condition	e contributing to	death but not	regulting	In the ur	dodulo		done le l	Part I. 24s. WAS AN			name and a tradeose
EDICAL	CAD with			Godin but not	readiting	m die di	derrynn	J ceuse g	iven in i	PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE
			20000							1 _ YES 2	DNO		OF DEATH?
Σ	DID TOBACCO U	SE CONTR	PIRLITE TO CA	LISE OF DEA	TH VE	ςПΙ	NO E	LINC	EDTAIN				1 NES 2 NO
A P	25. WAS CASE REFERRED TO		-		CE OF DEAT			ONC	EKIMI				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  1 Properties 2 ER/Outpatient 3 DOA  26. PLACE OF DEATH (Check only one)  OTHER:  1 VES 2 NO  1 Properties 2 ER/Outpatient 3 DOA  27. MANNER OF DEATH  28. DATE OF INJURY  28b. TIME OF INJURY AT WORK?  1 NURTH OF INJURY OCCURED  1 NURTH OF INJURY													
Ē	27. MANNER OF DEATH  286. DATE OF INJURY  280. DATE												
1 Neturel 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO													
28a PLACE OF IN HIDY - At home from about the control of the contr									loute Number,				
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as sta								) end menner as stated.					
H H									(Month, Day, Year)				
2	YT.	D 18769								6/95			
	30. HAME AND ADDRESS OF						h 0 = 1	an J	MD	21502	/	/	
	31. DATE FILED (Month, Day,			al Hospi		Cum	nell	and,	ru).	21502	-		
	JUN (		5 32. HEGISTRA	R'S SIGNATURE	rdall								
	0011	, 100											



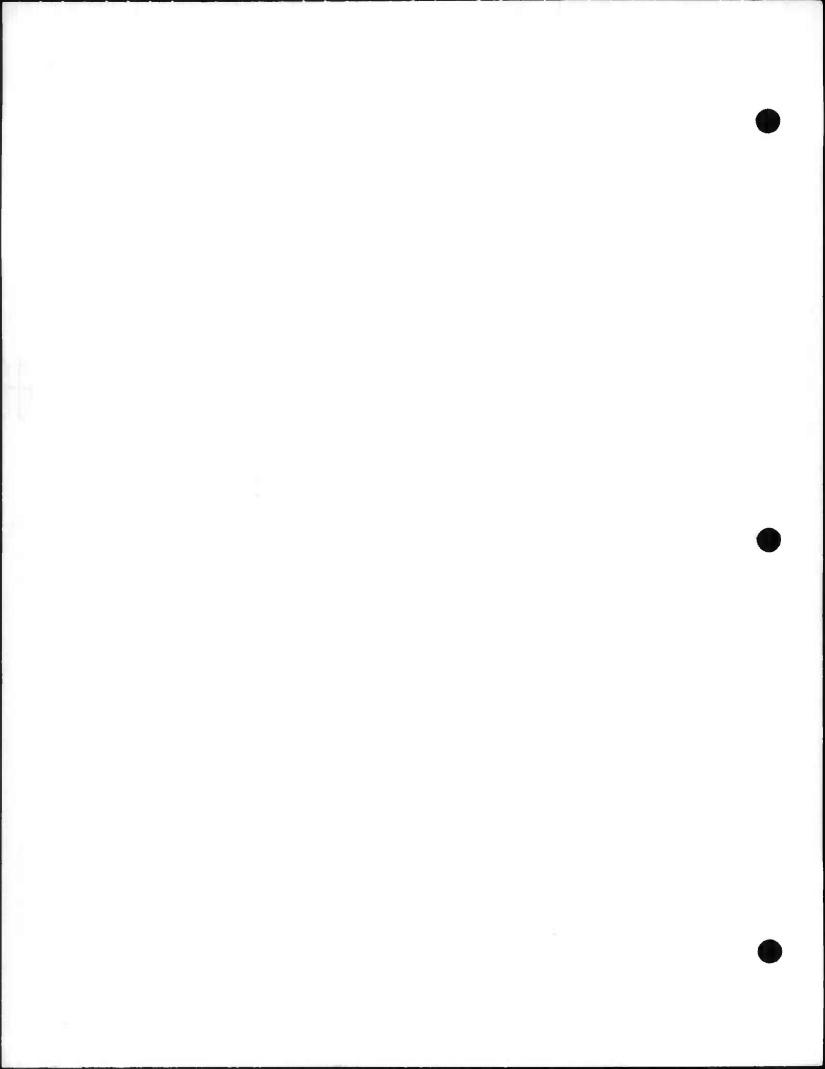
MARYLAND 21215-0020

DIVISION OF VITAL BECODE

THE HOSPITAL DR AT THE FUNERAL DIRECTION OF THE PROPERTY OF TH	BALLIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a from all the death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Memal Hygiene prior to bunial, cremation, or memoral
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	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
RAR	CERTIFICATE OF DEATH REG. NO.	

		FOR STATE REGISTRAR		STATE OF I	MARYLA	AND /	DEPAR	TMEN'	OF H	EALTH DEA	AND	MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Lest)  MARY LEE MERKEL  2. DATE OF DEATH MONTH DAY YEAR MONTH DAY OF DEATH MONTH DAY OF DEATH DAY OF DEATH MONTH DAY OF DEATH MONTH DAY OF DEATH DAY OF								3. TIME OF DEATH						
		4. SOCIAL SECURITY NUMBER 219-76-2609	1	SEX	8. AGE (#		birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	7. DA Feb	TE OF BURTH	1	B. BIRTNI	PLACE (State or Foreign )) MD
100	200	9a. FACILITY NAME (If not institution, give street and number)  MEMORIAL HOSPITAL  RESIDENCE OF DECEMENT  9b. CITY, TOWN OR LOCATION OF DEATH  CUMBERLAND  9c. COUNTY OF DEATH  ALLEGANY														
DIDECTOR		10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION  MD Allectany Cumbons and						10d. INSIDE CITY LIMITS? 1X YES 2 NO								
MEDAI	T T	100. STREET AND NUMBER  101. ZIP CODE  102. CITIZEN OF WHAT COUNTRY?  21502  USA								HAT COUNTRY?						
BY FIIN	5	11. MARITAL STATUS  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER FORCES? 1 YES				S 2 NO If yes, specify Cuban, Mexica				in, Puerto Rican, etc.) Spec			Specify Specify	- American Indian, , Whita, etc. y: Thite		
FTED		(Specify only high Elementary/Secondary (0-12)			+)	(Gh	ne kind of a Do NOT us	USUAL Owork done on retired.)	CCUPATIO	N It of worldr	ng	1	6b. KIND OF BU	SINESS/INDU		
once.		unknown  17. FATNER'S NAME (First, Middle,	Last)			No	ne			18 MOT	NED'S NA	ME (FI-	N/A t, Middle, Maiden	0		
76	. 1	Victor N.	Merke	1							neconica .		. (Fult			
TO BE	- 11	19e, INFORMANT'S NAME (Type/F	Print)			19b	MAILING	ADDRESS	(Street a		-		imber, City or Tow		Code)	
be no		Victor F. Me				51			_		; Cu	mbe	rland,		1502	
er must		20e. METHOD OF DISPOSITION  1A) Burlat 2 Cremation 3 Removel from State  20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crematory or other place)  SS Peter Paul Cemetery  06/02 Cumberland, MD														
medical examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Scarpelli Funeral Home  Cumberland, MD 21502														
#											Interval Between Onset and Death					
or other traumatic event,		Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  15 VIS  OUE TO (OR AS A CONSEQUENCE OF):														
y, or other traumatic		CAUSE (Disease or injury that initieted events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  d.														
any Inju		PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i.  24a. WAS AN AUTOPSY PERFORMED?  1  YES 2 NO OF DEATH?									AVAILABLE PRIOR TO COMPLETION OF CAUSE					
shows any	- 16	DID TOBACCO USE	CONTRIB	UTE TO CA	USE OF	DEAT	'H YE	SIII	NO E	LINC	ERTAIN					OF DEATH?
SICIAN		25. WAS CASE REFERRED TO ME EXAMINER?	DICAL	OSPITAL:				N (Check	only one)							
<u> </u>		1 ( YES 2 NO		☐ Inpetient 2 V		tlent 3		4 🗆 Nun	ing Nome		sidence		her (Specify)			
\$ 0		1 Netural 5 Pend		26e. DATE OF (Month, D	lay, Year)		28b. TIM	URY M	28c, INJU WOI	RY AT IK?	NO	28d. O	EŞCRIBE NOW II	NJURY OCCU	RED	
28 is TED	- 1	2 Accident Investigation 3 Suicida 6 Could not be determined 26a. PLACE OF INJURY — At home, ferm, streat, factory, office City or Town, State) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State)								oute Number,						
IMPORTANT: If item O BE COMPLE				N: To the best of On the bests of e												and manner sa stated.
PORTA BE		29b. SIGNATURE AND TITLE OF C	CERTIFIER	~~/						29c, LICE	NSE NUN	IBER		29d. DATE :	SIGNED (	Month, Day, Year)
2	-	30. NAME AND ADDRESS OF PER	ISON WHO CO	OMPLETEO CAUS	SE-OF DEAT	TN (ITEM	27) (Type,	1 ()	Be	1 /1	イノト	01	an L	上り上	30	45
7		31. DATE FILEO (Month, Day, Year)	1995	32. HEGISTRA	A'S SIGNAT	TURE				- 1	1	100				

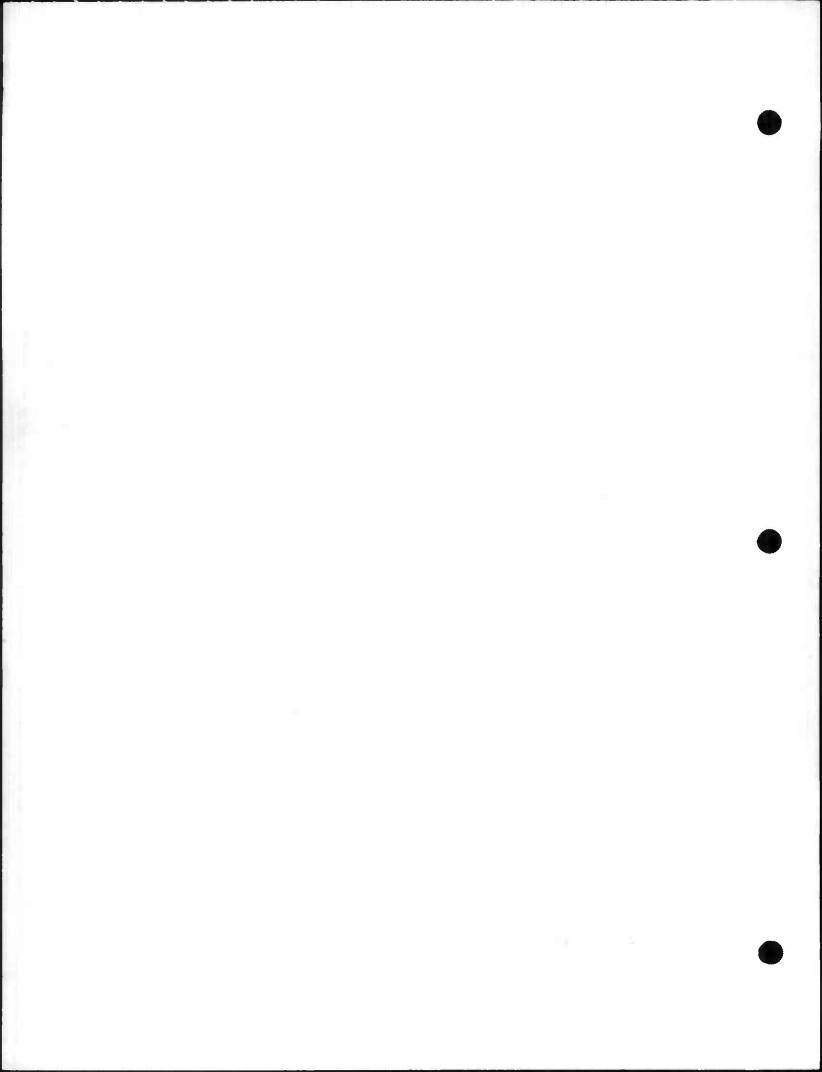


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within SC hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last) GEORGIA	LOUISE	MUNSON		2. DATE OF DEATH MONTH D. MAY 29,	AY YEA	3. TIME OF DEATH				
DIRECTOR	4. SOCIAL SECURITY NUMBER 723-07-8916	5. SEX 6. AGE (1	MONTH	DER 1 YEAR   IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar 25, 1	8. Bi	RTHPLACE (State or Foreign unitry)  WV				
	80. FACILITY NAME (If not institution, give atm SACRED HEART HOS	,		ITY, TOWN OR LOCATION OF DUMBERLAND							
	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY										
	MD Alle	gany	Pinto	N OR LOCATION		10d. INSIDE CITY LIMITS? 1 YES 2 X N					
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE			PF WHAT COUNTRY?				
NE	McMullen Village					USA					
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES  IF YES, GIVE WAR OR DA	2 XNO	I3. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico 1 YES 2 XNO Specify	an, Puerto Rican, etc.)	8	ACE — American Indian, leck, White, etc.				
COMPLETED	15. DECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12)	completed)	16a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire	ne during most of working	16b. KIND OF BU	White					
IPLI	12	College (1-4 or 5+)	Homemake:	r r	Own H	Iome	75.21.5				
ON	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Malden						
BE (	Allen Bohrer			Dais	ey (Gaithe	r)					
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADOR	ESS (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Code)					
	Diane Perrin			Box 199 Perri							
	20a_METHOD OF DISPOSITION  1 ②Burial 2 ☐ Cremation 3 ☐ Remove  4 ☐ Donation 5 ☐ Other (Specify)	val from State come	PLACE AND DATE OF DISP stery, cremetory or other plan	ce)	OATE 20c. LO						
	21. SIGNATURE OF FUNERAL SERVICE LICE	:NSEE		on Cemetery	06/01 Gr	eat Cac	apon, wv				
	22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502										
	23. PART   Enter the diseases, or co	inplications that caused	the death. Do not an	ar the mode of dying, suc	ch as cerdiac or reapi	ratory arrest,	Approximata				
	shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence or):										
NO	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING  b. CEREBRAL METALYASIS  DUE TO (OR AS A CONSEQUENCE OF):										
CATI											
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
	PART if. Other algolificant conditions	contributing to death be	it not reaulting in the	undarlying cause given in	Part i. 24s. WAS AN	AUTOPSY	4b. WERE AUTOPSY FINDINGS				
MEDICAL						FORMED? MAILABLE PRIOR					
Σ	DID TOBACCO USE CONTRI	RUTE TO CAUSE OF	DEATH VEC	AIO THUNCEPTAN			1 TYES 2 THO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		16. PLACE OF DEATH (Che		N L J						
Sic		HOSPITAL: 1 Dinpatient 2 ER/Output	tlant 3 DOA 4 N		Rasidenca 6 Other (Specify)						
À.	27. MANNEB OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT			26d. DE\$CRIBE HOW INJURY OCCURED					
ВУ	1 Netural 5 Pending 2 Accident Investigation	(month), buy, roury	INJURY M	WORK?							
	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Speci	At home, farm, street, f	ma, farm, street, factory, offica 261. LOCATION City or Tow			N (Street and Number or Rural Route Number, rn, State)				
COMPLET	29a. CERTIFIER 1 CERTIFYINO PHYSICI	AN: To the best of my knowle	edge, death occurred at the	time, data and place, and due	to the cause(s) and man	ner as stated.					
₩ O	29a. CERTIFIER (Check only one)  1 CERTIFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
BE	296. SIGNATURE AND TITLE OF CERTIFIER	MBER 7 - D	are are a series (moral, buy, par)								
2	30. NAME AND ADDRESS OF PERSON WHO DING SM B. SMAH.	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print)	-16H15, CUNBG		2/02	70331				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		1011/21 -01400		- ~(J0Z					
	MAY 3 1 1995 The Structur Revolate										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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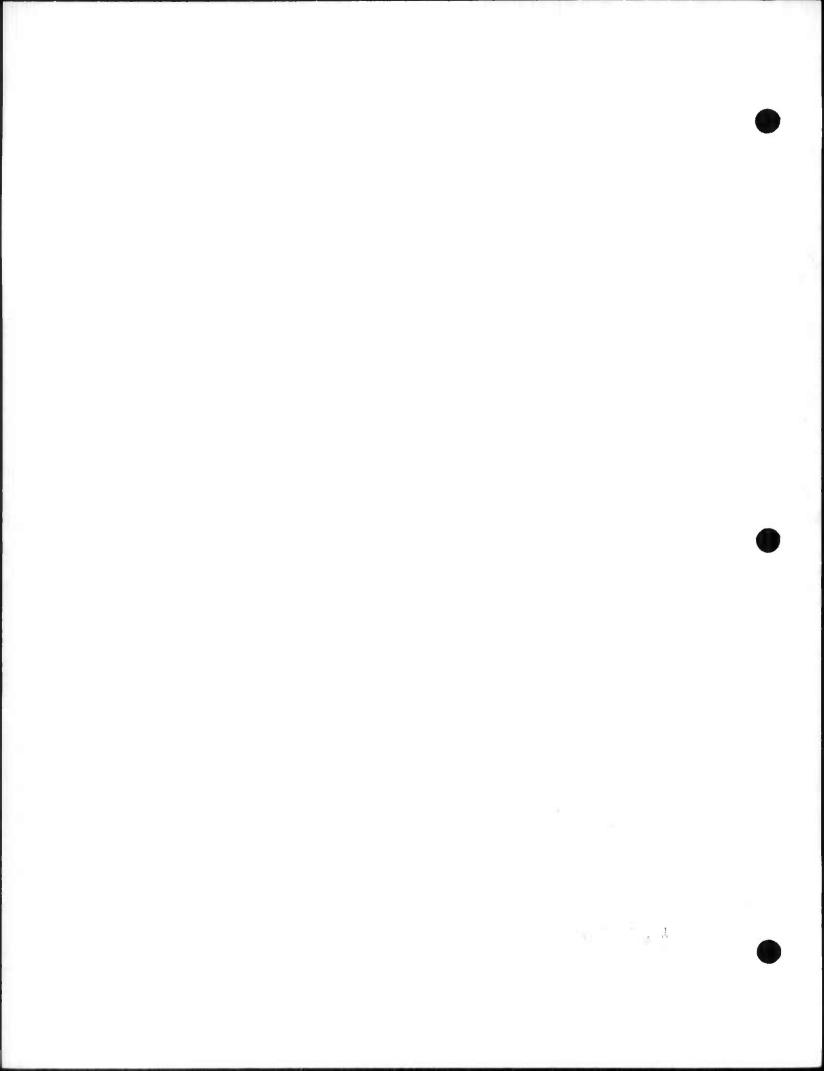
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIE	NE
		CE	ERTIFICATE	01	F DEAT	TH		REG. N	Ο.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	IEALTH AND M	IENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	OWEN	Noel	M	ORRIS		MONTH DA 1av 26, 19		4:40A. M				
~	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign				
	216-22-5828	1X M 2 □ F	68 YRS.	ONTHS DAYS	HOURS MIN.	Sept. 2, 1	1926	Maryland				
	9e. FACILITY NAME (If not institution, give st		9b. CITY, TOWN C	Sc. COUNTY OF	DEATH							
DIRECTOR	Memorial Hospital & Medical Center Cumberland Allegany							ıy				
EC	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY				
띰	Maryland Alleg	anv		Cumbei	cland			LIMITS?				
AL	10s. STREET AND NUMBER	-		. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?					
FUNERAL	620 Frederick St	•		21502		USA						
S	11, MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPANIC	C ORIGIN? (Specify Yes	or No.— 14. RAG	CE — American Indian,				
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR D		If yes, specify Cuban, Mexican, Puerto Rica  1  YES 2  NO Specify:				ck, white, etc.				
		WW II										
TE	15. DECEDENT'S EDUC (Specify only highest grade	completed)	18e. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during mo	ON sl of working	16b. KIND OF BUS						
PLE	Elementary/Secondary (0-12)	Coflege (1-4 or 5+)	Direct			Count						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		.01	18 MOTHED'S NAME	E (First, Middle, Melden :	ll Defense						
	Joseph Noel	Morris			Adelia		sumame)					
BE	19a. INFORMANT'S NAME (Type/Print)	1101110	19b. MAILING A	DDRESS (Street a		ute Number, City or Town	State Zin Code)					
5	Ellen V. Morris					berland, M						
	20a. METHOD OF DISPOSITION	201	PLACE AND DATE OF	DISPOSITION /No	me of	DATE 200 LOG	CATION - City or I	Town, State				
	1X Burial 2 Cremation 3 Remo	RO	cky Gap \	eterans	Cem. 5/3	30/95 Fli	ntstone	, MD				
	1X Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. SIGNATURE OF PANELAL SERVICE LUCKSEE  1X Burlai 2 Crematory or other place)  ROCKY Gap Veterans Cem. 5/30/95 Flintstone, 1  22. NAME AND ADDRESS OF FACILITY Kight Funeral Hol											
H	▶ William 4	9KMVV		309-31	1 Decatur	r St., Cum	berland	, MD 21502				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.											
	shock, or heart fallure. L IMMEDIATE CAUSE (Finel	List Only tone ceuse on e	ech line.					Approximate Interval Between Onset and Death				
	The state of the s	Respiratory	2 Days									
	Tooling in death)	DUE TO (OR AS A										
N	Sequentially list conditions,	Carcinomatosis 2 Years										
CERTIFICATION	If any, leading to immediate	Adenocarcin	0 **									
2	CAUSE (Disease or injury	DUE TO (OR AS A	2 Years									
Ē	thet initiated events resulting in deeth) LAST	000 10 (ON AS A	CONSECUENCE OF):									
CE		I.										
AL	PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED?											
음						1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ME						_,		1 - YES 2 - NO				
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR				UNCERTAIN	白						
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)  HOSPITAL: OTHER:										
14S	1 YES 2 NO  27. MANNER OF DEATH	1 ☑ Inpatient 2 ☐ ER/Outp	atient 3 DOA 4		5 Residence 8							
	1 Netural 5 Pending	(Month, Day, Year)	INJUR	WO!				OW INJURY OCCURED				
В	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, ferm, str			28f. LOCATION (Street or	of and Number or Paris Basis Number					
	4 Homicide 8 Could not be	building, atc. (Spec	elfy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State)	and Number or Rural Route Number,					
COMPLETED	29a. CERTIFIER CERTIFYING PHYSIC	TAN: To the heat of my know	andre Street consists		Swarn Silvers		71-07-CT/N					
MA		(Check only Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
	EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.  29b. SIGNATURE AND THE PROPERTY OF THE P											
	296. SIGNATURE 296. LICENSE NUMBER 29dA04T 91G											
20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type. P.	rint)	D 16041		11/000	AU, 1770				
5					<i>D</i> ************************************	umberland	MD 2	1502				
10		MemorialHosp	ital Medi		<i>D</i> ************************************	umberland,	MD 2	1502				



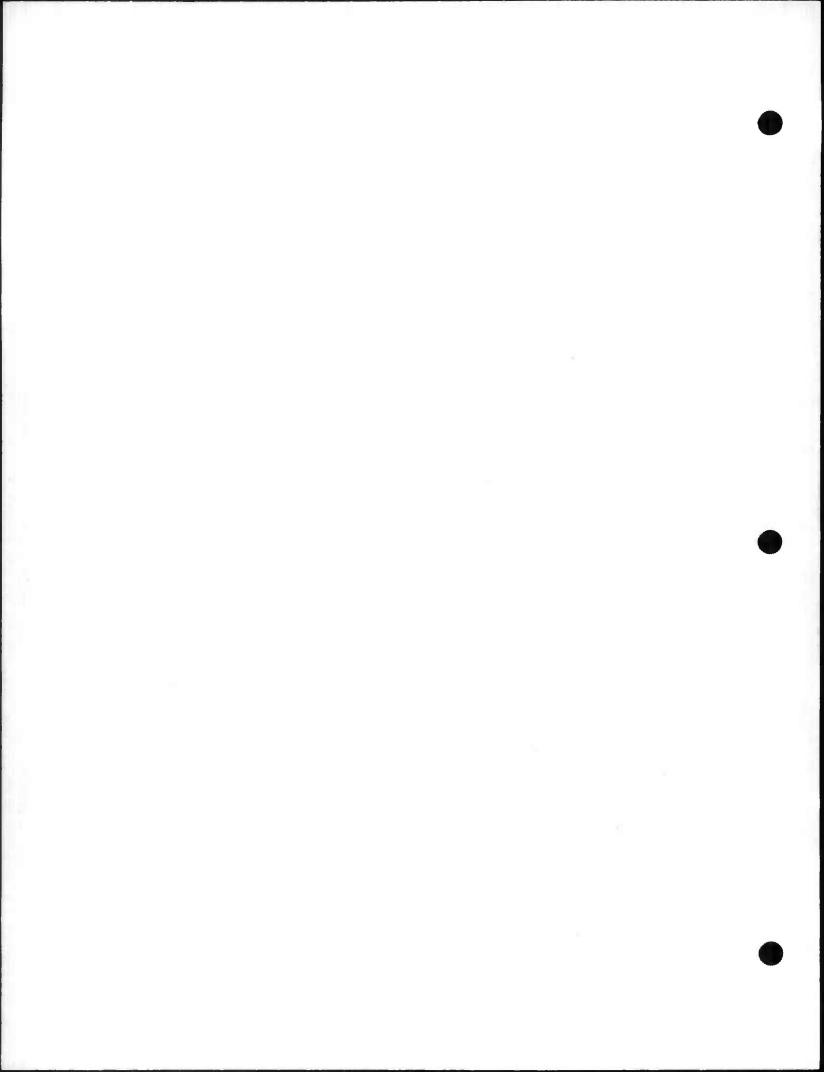
YEAR

3. TIME OF OFATH

2. DATE OF DEATH

funeral director, been signed by the attending physician and completely filled in by the nt. of Health and Mental Hygiene prior to burial, cremation, or removal. HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with has be Dept. After this certificate death with the State DIRECTOR: A

MAY" 27, 1995 JANE ELLEN MITCHELL 07:30 A. M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 218-24-8141 DAYS JUNE 3 1930 1 - M 2 XF 64 MARYLAND for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SACRED HEART HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 2 NO MARYLAND ALLEGANY CUMBERLAND FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 509 FURNACE STREET 21502 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) YES 2 NO BY Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) detached 12 CLERK/SALESPERSON RETAIL RETAIL SALESPERSON 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) page 5 should be Ħ CHARLES R. HIMMLER DOLLY T. KREGER notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 PATRICK HIMMLER 825 SHRIVER AVE CUMBERLAND MARYLAND must be 20a. METHOD OF DISPOSITION
1 ☑ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 1 Donation 5 Other (Specify) DATE 20c. LOCATION - City or Town, State PATRICKS CEMETERY MAY 30 1995 CUMBERLAND MARYLAND medical examiner ALLINE OF FUNERAL SERVICE WENTER 22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, Dr heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) event. traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if sny, isading to immediate cause. Entar UNDERLYING CAUSE (Disesse Dr injury other that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO W UNCERTAIN I 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL:
10 Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 TYES 2 NO ng Home 5 - Rasidenca 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1.0 Natural 1 YES 2 NO BY nvestigation Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 ETED 6 Could not be Item 28 4 Homicide hours 2 29a, CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho (Check only one) MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND THE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 27-1995 26 ► MAY 2 WHO COMPLETED CAUSE OF DEATH-TIEM 27) (Type, Print) 909 B SETON DRIVE CUMBERLAND, MD. 21502 JOHN MEHANNA, M.D. 32 REGISTRAR'S PCHATURE



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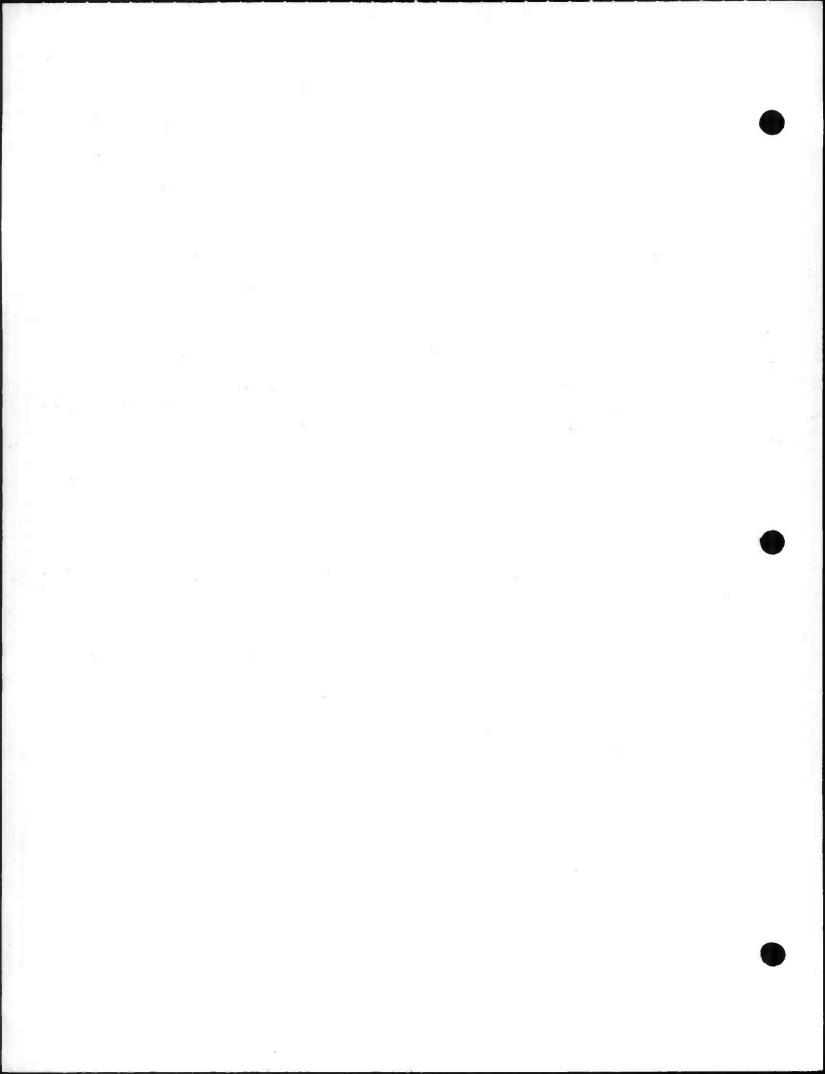
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	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF BEATH	REG. NO.

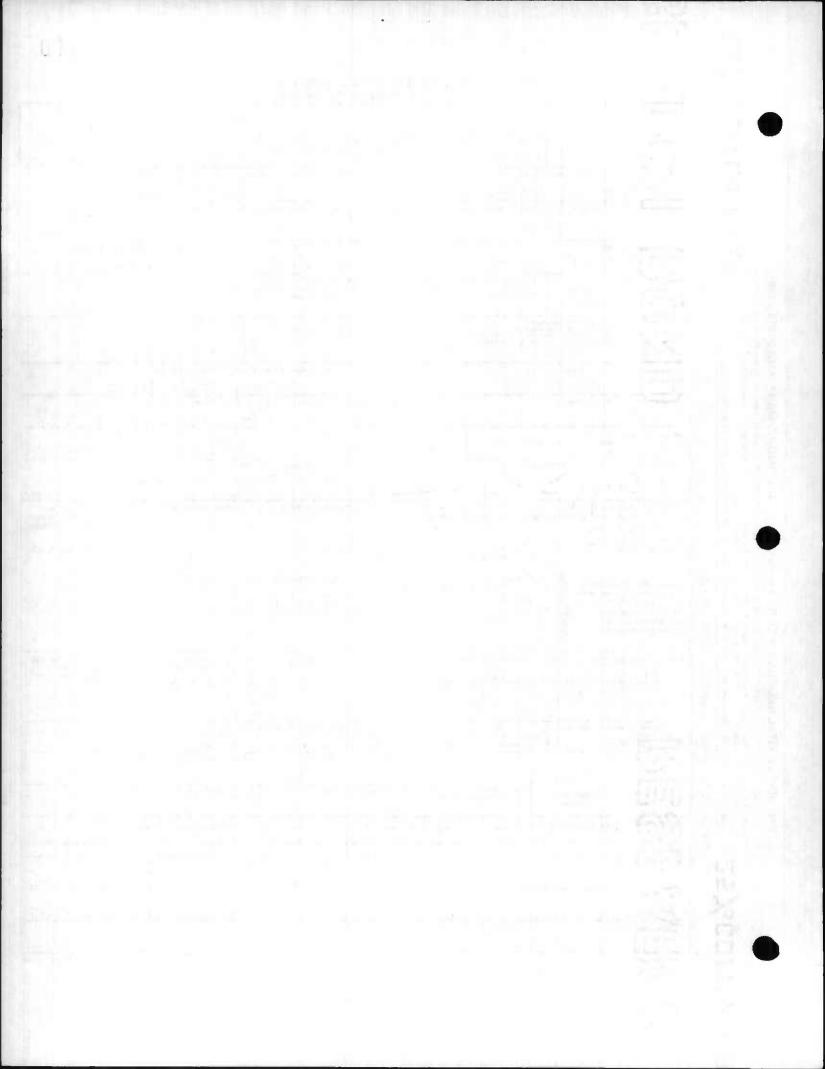
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H	EALTH AND DEATH	MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, MIGGRE, Last) IGOR A. NO	VIKOFF				2. DATE OF GEATH MONTH 28,	1995 YEAR	3. TIME OF OEATH 5:30 PM M		
	4. SOCIAL SECURITY NUMBER 227-07-3760	1 🖾 M 2 🗆 F	(In yrs. last birthday) 92 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 17,	Cou	THPLACE (State or Foreign only)		
TOR	90. FACILITY NAME (If not institution, give BROOKE GROVE NUR	SING HOME		96. CITY, TOWN O	PR LOCATION OF 0	9c. COUNTY OF DEATH Montgomery				
FUNERAL DIRECTOR	10a. STATE 10b. COUNT	gomery		y, town on Locat				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ERAL	3585 South Leisur	e World Blv		20906		10g. CITIZEN OF WHAT COUNTRY?				
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	8 2 NO	13. WAS OEC If yes, spo 1 YES	city Cuban, Mexico	NIC ORIGIN? (Specify Yes en, Puerto Riceri, etc.) fy:	Die	CE — American Indian, ick, White, atc. scily: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a		st of working	16b. KIND OF BUS	BINESS/INDUSTRY			
ME	17. FATHER'S NAME (First, Middle, Lest)	4	Mechani	cal Engi			al Comp	any		
	Alexander Noviko	off			Natalia	ME (First, Middle, Maiden	Sumame)			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS /Street a		Route Number, City or Town	State 7to Codel			
2	Leon Boulavsky					al Hills, M		20743		
	20e, METHOD OF DISPOSITION 1  Burlel 2  Cremetlon 3  Rem 4  Donetton 5  Other (Specify)	DATE 20c. LOC								
	21. SIGNATURE OF FUNERAC SERVICE LA		Rock Cree	22. NAME AN	D ADDRESS OF FA	CLUTY Hines-R	inaldi F	uneral Home		
	1/1/5	1/2		Silve	New Har er Sprin	mpshire Ave g, Maryland	enue 1 20904			
	IMMEDIATE CAUSE (Final	List only one cause on	aach line.				ratory arrest,	Approximate Interval Between Onset and Death		
	disease or condition resulting in death) s. CRRBROVASCUVAR ACCIDENT									
z	DUE TO (OR AS A CONSEQUENCE OF):  ARTERIOSCLEROSIC CEREBRONASCHUAR OI FUNS-E									
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									
CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENCE OF	7):						
AL C	PART II. Other significant condition	ns contributing to death	but not resulting	n the underlying	csuse given in	Pert I. 24e. WAS AN	AUTOPSY 24	Ib. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICA						PERFORI	MED?	AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO		
ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE (	OF DEATH YE	S I NO	UNCERTAIL	N 🗆		, , , , , , , , , , , , , , , , , , ,		
CF	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEAT							
ΙλS	1 TYES 2 THO	1   Inpetient 2   ER/Out				6 Other (Specify)				
ВУ РН	27. MANNER OF DEATH  1 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1 V	ES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED			
ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Spi	ecify)			281. LOCATION (Street as City or Town, State)		Route Number,		
COMPL	2 MEDICAL EXAMINE	ICIAN: To the best of my know	wiedge, death occurre on and/or investigatio	d at the time, data n, in my opinion, de	and place, and due	time, data and place, and	ner as stated. I due to the cause	(a) and menner as stated.		
O BE	29b. SIGNATURE AND TITLE OF CERTIFIES	- mo			P 2	4543		D (Month, Day, Year)		
	DR. JAMES A. ROS	SSI 330.	5 N. Leis	ure Worl	d Blvd,	Silver Spr	ing, MD			
	MAY 3 0 1995	32 REGISTRAR'S SIGN	NATURE							



1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, Last) Dorothy	Elizabeth	No	okes			June 5	, DAY 19	95ª	5:00 a
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last bi		t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		S. BIRTHE	PLACE (State or Foreig
	578-20-4217	1 M 2 M F	84	YRS. MONTHS	DAYS H	HOURS MIN.	(Month, Day, Year) Country)			)
	Sa. FACILITY NAME (If not institution, give	41	J-1	9b. CIT	, TOWN OR	LOCATION OF D			Wash	ington,D
Œ	7810 Clark Road	Lot B-4								
CTOR	RESIDENCE OF DECEDENT	TOL D-4		1 16	essup			I_Ann	e Arı	undel
ш	10e. STATE 10b. COUNT			10c. CITY, TOWN	OR LOCATION	N	11000		T	10d. INSIDE CITY LIMITS?
DIR	Maryland Ann	e Arundel		Jessur						1 YES 2 X N
AL	10a, STREET AND NUMBER				10f. Z	IP CODE		10g. CITIZ	EN OF W	HAT COUNTRY?
<b>E</b>	7810 Clark Road	Lot B-4				20794		U.	S.A.	
FUN	11. MARITAL STATUS	12. WAS DECEDENT EX		0 13.			NIC ORIGIN? (Specify	Yes or No-	14. RACE	- American Indian White, etc.
ВУ	1 Never Merried 2 Married  3 Wildowed 4 Divorced			NO Specif	nn, Puerto Rican, etc.) y:		Specify	/:		
		1								white
ETED	15. DECEDENT'S EDI (Specify only highest grad		(Give	DENT'S USUAL C	during most o	of working	16b. KIND OF	BUSINESS/IND	USTRY	
	Elementary/Secondary (0-12) Grade 8	College (1-4 or 5+)		o NOT use retired.) es Clerk			2	-	<b>a</b> .	
COMPL			Sate	s cierk	-			rtment	Stor	ce
_	17. FATHER'S NAME (First, Middle, Last) RUSSell Birckhead	a			,		ME (First, Middle, Mak		-	
BE		<u> </u>					aret Este		_	1
2	19a. NFORMANT'S NAME (Type/Print)  John Nokes						Route Number, City or			
							B-4 Jes			
	20e. METHOD OF DISPOSITION 1	noval from State	cometery, crema	DATE OF OISPO	SITION (Name	of	6/6/	LOCATION 0		
10	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE D		atonsvi	lle	Maryla					
	ATT. SIGNATURE OF PUNERAL SERVICE L	7				ADDRESS OF FA	our Ineral Hor	00 D 7		
	greye-	) top		_			Avenue I			C Factor
RTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. Conges DUE TO (OR  C. Cerahio DUE TO (OR	AS A CONSEQUE	Heart- ENCE OF):	fa	ilure				how
00	that initiated events									
8		d								
8	that initiated events	d.	ath but not rea	ulting in the u	nderlying c	euse given in	Part I. 24a. WAS	AN AUTOPSY	24b.	
8	that initiated events resulting in death) LAST  PART II. Other significant condition	d	ath but not rea	ulting in the u	nderlyling c	ceuse given in	PERI	ORMED?		AMAILABLE PRIOR T
EDICAL CE	that initiated events resulting in death) LAST  PART II. Other significant condition	April 1	ath but not rea	ulting in the u	nderlying c	ceuse given in	PERI			AMAILABLE PRIOR T COMPLETION OF CA OF DEATH?
MEDICAL CE	that initiated events resulting in death) LAST  PART II. Other significant condition	April 1	ath but not rea	ulting in the u	nderlying c	ceuse given in	PERI	ORMED?		AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?
MEDICAL CE	PART II. Other significant condition  Atnal thin  25. WAS CASE REFERRED TO MEDICAL	Halwn	ath but not rea		26. PLAC	Couse given in	PERI 1 TYES	ORMED?		AMAILABLE PRIOR T COMPLETION OF CA OF DEATH?
MEDICAL CE	PART II. Other significant condition  Atrial Juhn	April 1		OTHE	26. PLAC	CE OF DEATH (C)	PERI 1 TYES	ORMED?		AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?
EDICAL CE	PART II. Other significant condition  Atrical thin  25. Was Case Referend to Medical  EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH	HOSPITAL:	VOutpetient 3 🗆	OTHE	26. PLAC	CE OF DEATH (CA 5 M Residence TY AT	PERI 1 ( YES	FORMED?		AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?
PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Atnot thin  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   YES 2   NO	HOSPITAL: 1   Inpetient 2   ER 28a. DATE OF INJ (Morth, Day, Y	VOutpatient 3   2	DOA 4 Nu 25b. TIME OF NJURY	26. PLAC R: rsing Home 28c. INJUR WORK 1 YES	CE OF DEATH (CA 5 M Residence TY AT	PERI 1 YES  veck only one) 5 Other (Specify)  28d. DESCRIBE HO	W INJURY OCC	URED	MAILABLE PRIOR T COMPLETION OF C OF DEATH? 1 YES 2 N
BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Street Laboratory  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide a Could not be	HOSPITAL: 1   Inpetient 2   ER	VOutpetient 3  URY 2 IJURY — Al home	DOA 4 Nu 25b. TIME OF NJURY	26. PLAC R: rsing Home 28c. INJUR WORK 1 YES	S Residence	PERI 1 YES  neck only one)  5 Other (Specify)	W INJURY OCC	URED	MAILABLE PRIOR T COMPLETION OF C OF DEATH? 1 YES 2 N
BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Atract thin  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be determined	HOSPITAL: 1   Inpetient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IN	VOutpetient 3  URY 2 IJURY — Al home	DOA 4 Nu 25b. TIME OF NJURY	26. PLAC R: rsing Home 28c. INJUR WORK 1 YES	S Residence	PERI 1 YES  1 YES  1 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)	W INJURY OCC	URED	MAILABLE PRIOR I COMPLETION OF C OF DEATH?  1 YES 2 N
ETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Atract thin  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide a Could not be determined  290. CERTIFIER (Check only 1) CERTIFIYING PHY:	HOSPITAL: 1   Inpetient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IN	VOutpatient 3 □ IURY □ 2 IJURY — All home (Specify)	DOA 4 Nu 256. TIME OF BUJURY M b, farm, street, fac	26. PLAC R: sing Home 28c. INJUR WORK 1  YES tory, office	S Residence Y AT 3 2 NO	PERI 1 YES  The YES	W INJURY OCC	URED or Rural Ro	MAILABLE PRIOR I COMPLETION OF C OF DEATH?  1 YES 2 N
ETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Atrock thin  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH  1   Netural   5   Pending Investigation  2   Accident   Investigation  3   Suicide   a   Could not be determined  29e. CERTIFIER (Check only)   1   CERTIFYING PHYSICAL CONTINUED IN CERTIFYING PHYSIC	MOSPITAL:  1   Inpetient 2   ER  28e. DATE OF INJ (Month, Day, )  28e. PLACE OF IN building, etc.	VOutpetient 3   2   2   2   2   2   2   2   2   2	DOA 4 Nu 25b. TIME OF 9JURY M b, farm, street, fac	28. PLAC R: Ring Home 28c. INJUR WORK 1  YES tory, offica	S Residence Y AT 7 3 2 NO	PERI 1 YES  seck only one)  5 Other (Specify)  28d. DESCRIBE HO  28f. LOCATION (Stre City or Yours, St	W INJURY OCC	URED or Rural Ro	MARIABLE PRIOR T COMPLETION OF CA OF DEATH? 1 YES 2 N
COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  Atrock thin  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH  1   Netural   5   Pending Investigation  2   Accident   Investigation  3   Suicide   a   Could not be determined  29e. CERTIFIER (Check only)   1   CERTIFYING PHYSICAL CONTINUED IN CERTIFYING PHYSIC	HOSPITAL: 1   Inpetient 2   ER 28a. DATE OF INJ (Month, Day, Y 28a. PLACE OF th building, etc.  SICIAN: To the best of my	VOutpetient 3   2   2   2   2   2   2   2   2   2	DOA 4 Nu 25b. TIME OF 9JURY M b, farm, street, fac	26. PLAC R: R:Insing Home 28c. INJUR 1	S Residence Y AT 7 3 2 NO	PERI 1 YES  1 YES  5 Other (Specify)  2ed. DESCRIBE HO  2er. LOCATION (Stre City or Yours, St.	W INJURY OCC  wet and Number and Number and due to the	URED  or Rural Ro  ad. a cause(e)	MAILABLE PRIOR T COMPLETION OF C OF DEATH?  1  YES 2 N  oute Number,
BE COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide a Could not be datermined  29. CERTIFIER (Check only one)  2 MEDICAL EXAMIN	HOSPITAL: 1   Inpetient 2   ER 28a. DATE OF INJ (Month, Day, Y 28a. PLACE OF th building, etc.  SICIAN: To the best of my	VOutpetient 3   2   2   2   2   2   2   2   2   2	DOA 4 Nu 25b. TIME OF 9JURY M b, farm, street, fac	26. PLAC R: R:Insing Home 28c. INJUR 1	SE OF DEATH (C):  5 Residence TY AT TY 3 2 NO  nd place, and due th occured at the	PERI 1 YES  1 YES  5 Other (Specify)  2ed. DESCRIBE HO  2er. LOCATION (Stre City or Yours, St.	W INJURY OCC  wet and Number and Number and due to the	URED  or Rural Ro  ad. a cause(e)	1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL CE	PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide a Could not be datermined  29. CERTIFIER (Check only one)  2 MEDICAL EXAMIN	HOSPITAL: 1   Inpetient 2   ER 25e. DATE OF INJ (Month, Day, Y 28e. PLACE OF IN building, etc.  SICIAN: To the best of my IER: On the best of exami	IVOutpatient 3 URY (Seer) 2  IJURY — All home (Specify) knowledge, death Instion end/or invo	DOA 4 Nu 25b. TIME OF BYJURY M b, farm, street, fac	26. PLAC R: R:Insing Home 28c. INJUR 1	SE OF DEATH (C):  5 Residence TY AT TY 3 2 NO  nd place, and due th occured at the	PERI 1 YES  1 YES  5 Other (Specify)  2ed. DESCRIBE HO  2er. LOCATION (Stre City or Yours, St.	W INJURY OCC  wet and Number and Number and due to the	URED  or Rural Ro  ad. a cause(e)	MARLABLE PRIOR TI COMPLETION OF CA OF DEATH?  1 YES 2 No oute Number, and menner as sta
BE COMPLETED BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST  PART II. Other significant condition of the	HOSPITAL: 1   Inpetient 2   ER 25e. DATE OF INJ (Month, Day, Y 28e. PLACE OF IN building, etc.  SICIAN: To the best of my IER: On the best of exami	IVOutpatient 3 URY (Seer) 2  IJURY — All home (Specify) knowledge, death Instion end/or invo	DOA 4 Nu 25b. TIME OF BYJURY M b, farm, street, fac	28. PLAC R: R: 28c. INJUR WORK 1  YES tory, offica	SE OF DEATH (C):  5 Residence TY AT TY 3 2 NO  nd place, and due th occured at the	PERI 1 YES  1 YES  5 Other (Specify)  2ed. DESCRIBE HO  2er. LOCATION (Stre City or Yours, St.	W INJURY OCC  well and Number and state and due to the 29d, DATE	URED  or Rural Ro  ad. a cause(e)	MAILABLE PRIOR T COMPLETION OF CA OF DEATH?  1  YES 2 N  oute Number,  and menner as sta
BE COMPLETED BY PHYSICIAN: MEDICAL CE	That initiated events resulting in death) LAST  PART II. Other significant condition with the condition of t	HOSPITAL: 1   Inpetient 2   ER 25e. DATE OF INJ (Month, Day, Y 28e. PLACE OF IN building, etc.  SICIAN: To the best of my IER: On the best of exami	VOutpatient 3   2   2   2   2   2   2   2   2   2	DOA 4 Nu 25b. TIME OF BYJURY M b, farm, street, fac	26. PLAC R: R:Insing Home 28c. INJUR 1	SE OF DEATH (C):  5 Residence TY AT TY 3 2 NO  nd place, and due th occured at the	PERI 1 YES  1 YES  5 Other (Specify)  2ed. DESCRIBE HO  2er. LOCATION (Stre City or Yours, St.	W INJURY OCC  wet and Number and Number and due to the	URED  or Rural Ro  ad. a cause(e)	MANLABLE PRIOR TICOMPLETION OF CA OF DEATH?  1 YES 2 No



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

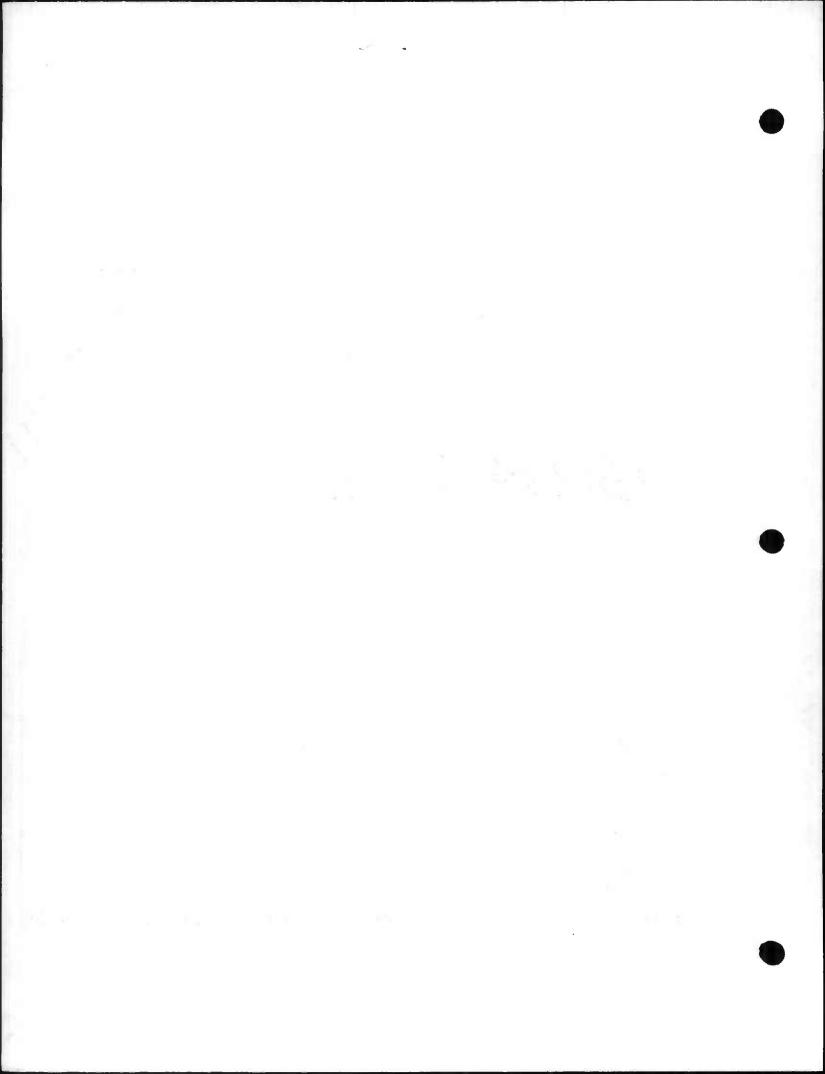
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

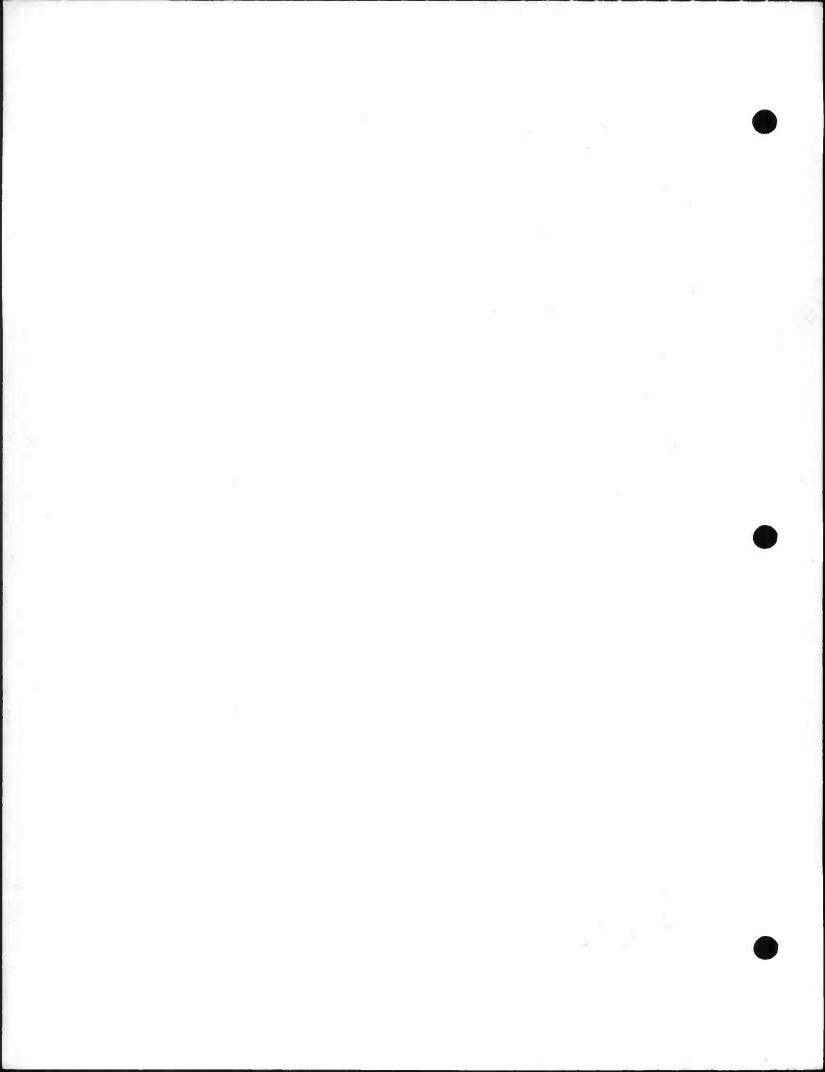
	REGISTRAR	CERTIF	ICALE	JE DEATH	REG. N	O.				
	1. OECEDENT'S NAME (First, MICHIGO, LOSI)  BARBARA H. NUTTER				2. DATE OF OEATH MONTH JUNE 2,	1995	YEAR	ME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE 1	(In yrs. lest birthday) 49 YRS.	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year) JAN. 12			E (State or Foreign		
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TO	VN OR LOCATION OF DE			TY OF DEATH	MILIA		
DIRECTOR	12425 DEREK PLACE			WALDORF		CHARLES				
H	10s. STATE 10b. COUNTY	1	Y, TOWN OR LO				10d.	INSIDE CITY LIMITS?		
	MARYLAND CHARLES		WALDORF			1 TYES 2 X NO				
FUNERAL	106. STREET AND NUMBER 12425 DEREK PLACE		101. ZIP CODE 20601				10g. CITIZEN OF WHAT COUNTRY?			
BY FUR	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13, WAS If yes	DECENDENT OF HISPAN , specify Cuban, Mexica YES 2 NO Specify	IIC ORIGIN? (Specify Y n, Puerto Rican, atc.) /:	es or No	14. RACE — Ar Black, White Specify: WHIT			
	15. OECEDENT'S EDUCATION	16a. OECEDENT'S	USUAL OCCUP	ATION	16b, KIND OF B	ISINESS/IND		E		
ET	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of v	work done during	most of working	IOD. KIND OF B	James Salmer	SINT			
COMPLETED	2	MANAGEM	ENT AN	ALYST	DEPART	MENT O	F DEFE	ENSE		
	17. FATHER'S NAME (First, Middle, Last)  GERALD HAMILL			16. MOTHER'S NA	ME (First, Middle, Meide	n Surname)	GR	RAY		
TO BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAJLING	ADDRESS (Str	et end Number or Rural I		wn, State, Zip (		-		
۲	SUSAN DEWEY	321 KI	NG CRO	FT, CHERRY	HILL, NJ	08034				
	1 IN Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Telery, MARY					Ity or Town, St	RYLAND		
	BENJAMIN M. MATTHEWS M-0	0658		HUNTT FUN BOX 156		INC	ND 200	.04		
$\neg$	23. PART I. Enter the diseases, or complications that cause	d the death. Do n	ot antar tha	mode of dying, such	h as cardiac or rea	piratory arre		Approximata		
	shock, or heart failure. List only one cause on a	each line.	0	A -	TOTAL SECTION			interval Batween Onset and Death		
	disease or condition resulting in death)	y mo	Xon	alls			i			
	DUE TO AN AS A CONSEQUENCE OF:									
NO	Sequentially list conditions,  DUE TO (OR AS A CONSEDUENCE OF):									
CERTIFICATION	cause. Enter UNDERLYING	A CONSEDUCTOR OF	,.				j			
Ē	that initiated events	A CONSEQUENCE OF	F):							
	resulting in death) LAST									
	PART ii. Other significant conditions contributing to death it	out not resulting i	n tha underi	ying cause given in	Part i. 24a. WAS A	N AUTOPSY	24b, WERE	AUTOPSY FINDINGS		
EDICAL					PERFO	RMED?	AMAIL	ABLE PRIOR TO PLETION DF CAUSE		
MEC					1 TYES	200		YES 2 NO		
	DID TOBACCO USE CONTRIBUTE TO CAUSE C	OF DEATH YE	S 🗆 NO	☐ UNCERTAIN	10					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEAT		ne)						
YSI	1 YES 2 ND 1 Inpetient 2 ER/Out	patient 3 🗆 DOA	OTHER: 4 Nursing i	fome 5 Residence	6 Other (Specify)					
	27. MANNER OF OEATH  1. Natural 5 Pending  28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY	INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCU	JRED			
À	2 Accident Investigation 28s. PLACE OF INJUST	( — At home form a		YES 2 NO	204 1 00171011 (0)					
COMPLETED	8 Could not be building, etc. (Spe	city)	moot, tactory, t	ATTEC STATE OF THE	281. LOCATION (Street City or Town, State	and Number o	r Hurai Houte N	umber,		
29e. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Š	one) 2 MEDICAL EXAMINER: On the basis of examination	n and/or investigation	n, in my opinio	n, death occured at the	time, date and place, a	nd dua to the	cause(a) and r	nanner as stated.		
w II	296. SIGNATURE AND THE HOUSE ENTIFFED.			29c. LICENSE NUM	BER	29d. DATE	SIGNED MODIT	Dify, Year)		
10 B	1 y January			10176	05	10	1519	5		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE			N. 1 N	101	, 1	V			
	31. DATE FILED (MAN) Day for 1995 32 Jegistral) Sign	Tab V	Voog	yard R	d Cli	stor	MO	20735		
J.	JUN U 6 1995 Steller do The all	corplandall		,						



1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

	_	REGISTRAN				niir	ICALE	UL	DEAL	П		REG. NO.			
		1. DECEDENT'S NAME (First, Mido	lle, Last)								2. DATE	OF DEATH			. TIME OF DEATH
		Oh a sal a a	7.7.2	114			~				May		199	YEAR	2 2 M
		4. SOCIAL SECURITY NUMBER	W 1	SEX 3 AM	6. AGE (In yrs. las	right birthday	IF UNDER		IF UNDER	24 MD0		OF BIRTH	193		ACE (State or Foreign
		216-30-4034		₩ 2   F	60	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	ne 2	34	Country)	ACE (State or Foreign
Ð				2411		THS.					Ju	ne z	34	Wasr	n. D.CC
should		9e. FACILITY NAME (If not institution	on, give street o	end number)			9b. CITY,	TOWN	OR LOCATIO	ON OF DE	ATH		9c. COUN	ITY OF DEA	TH
9	8	18815 Wasch	ne Roa	ad			Dic	ke	rson				Mor	ntgon	nerv
. 2.	DIRECTOR	RESIDENCE OF DECEDI	ENT												
S	ŭ l		COUNTY			10c. CIT	Y, TOWN O	R LOCA	ATION					1	0d, INSIDE CITY
Z.	뛰	MD MC	ontgo	mery		D	Y, TOWN O	rsc	on						LIMITS?
permit. Pages		10e, STREET AND NUMBER						1							YES 2 NO
<b>B</b>	٨ ا	18815 Wasch	DO PO	a d				10	20842	5			10g. CITI	S.A.	AT COUNTRY?
020 physician. burial-transit	FUNERAL	10013 Wasci	ie ko	20042			Z			0.	. S . A .				
020 physician. burial-tran	5	11. MARITAL STATUS			EVER IN U.S. AR		13. V	MAS DE	CENDENT O	F HISPAN	HC ORIGIN	7 (Specify Yes	or No-	14. RACE -	- American Indian.
DD2 phys		1 Never Merried 2 Merri		FORCES? 1	YES 2 N	10	н	yes, s	pecify Cube S 2 NO	n, Mexica	n, Puerto F	ticen, etc.)			White, etc.
B 8	В	3 Widowed 4 Divorced			-1957		_   '	☐ 11E	3 2 MU NO	Specin	γ:			Specify:	white
15 as		15. DECEDEN	IT'S EDUCATIO			CEDENTIE	USUAL OC	CHIDAT	ION		Lags	KIND OF BUS	111500 (1115)	LIGTON	WIIICC
	ETE	(Specify only high			(Gi	ve kind of	work done d	during m	ost of workin	g	100	KIND OF BUS	MESS/IND	USINT	
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ALTIN death. Pag e funeral dir I.		N . / 11 .		1/14	-			Hi	lton	Fur	era	1 Hom	0		
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Ours after of in by the or remova		23. PART I. Enler the diseas	es, or comp	olicationa thet	caused the de	eth. Do I	not enter	the m	ode of dvi	ng. auc	h an card	lac or respi	retory arm	ent.	Approximate
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CORDS res that the d signed by the teatth and Mer	EDICAL	PART II. Other aignificant or	onditiona co	intributing to	deeth but not n	esulting	in the und	derlyin	ng cause g	jiven in	Part I.	24a. WAS AN PERFOR			VAILABLE PRIOR TO
OR that any amy												1 TES 2	4	0	OMPLETION OF CAUSE
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E VITA SICIAN: The certificate the State	S	1 TYES 2 10			ER/Outpatient 3	□ DOA			me 5 Re	sidence	8 🗆 Other	(Specify)			
OF V PHYSICIA This certif with the	Ή	27. MANNER OF DEATH		26e. DATE OF		26b. TIM	E OF		JURY AT		28d. DES	CRIBE HOW II	NJURY OCC	URED	
NG PHYS frer this ceath with marked	9	1 Natural 5 Pendi		(Month, Da	ly, 194r)	IN.	IURY M	1 🗌	ORK? YES 2	NO					
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DIVISION  OR ATTENDING F  DIRECTOR: After thours after death  Item 28 is mar	E	Tionneloe opien	illing d												
DIV DIREC DIREC Hours Item	ا ت	290. CERTIFIER 1 CERTIFYIN	IG PHYSICIAN	: To the best of	my knowledge, de	ith occum	nd at the tir	me dat	e end place	and due	to the cau	ee/s) and man	por se state		
로 달 전 도	COMPLET														nd menner as stated.
OSP UNE ithin	8 1						ni, in my op	pitnott,	Owath Occur	ed at the	time, uate	end piece, en	a ane to the	) ceuse(s) e	nd menner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If		296. SIGNATURE AND TITLE OF C	ERTIFIER	> /					29c. LICE	NSE NUN	ABER		29d. DATE	SIGNED (N	forith, Day, Year)
TO THE HOSP! TO THE FUNEP Be filed within		1		R					1015	160	<		1 7		2 1000
FFB	임	30. NAME AND ADDRESS OF PER	SON WHO CO	MPLETED CAUS	E OF DEATH (ITE	1 27) (Time	Print				200			371 €	4, 1775
		DE PALL	0011		A / /, /	24		•	6		C1	OL	110	7	^ /
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		31. DATE FILED (Month, Day, Year)	1005	32. REGISTRAF	Signature	2 0 .6									
		JUN 02	1995	julia a	amarter !	well									



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BALTIMORE, MARYLAND 21215-0020	hospita	ached f
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P.O. I	ath certificat	ttending phy
DS, P.O. BOX 68760,	the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physicis	the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with burs after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should	on, or removal.	s, or ttem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
e death certificate be executed within	he attending physician and completely	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	jury, or other traumatic event,
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the	be filed within 72 hours after death with the State Dept. of Health and M	APORTANT: If item 28 is marked, or Item 23 shows any Inju

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND N	MENTAL HYGIEN REG. NO.	Ē			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Charles Ma	thue	NICE			JUne 2,		7:45 P M		
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign		
	236-20-1726	▼ M 2 □ F		THE DAYS	HOURS MIN	(Month, Day, Year)	Count	(YY)		
	9a. FACILITY NAME (If not institution, give stree	21		CITY TOWN O	R LOCATION OF DE	Mar. 29, 1	922 Wes	t Virginia		
DIRECTOR	Cuppett-Weeks Nurs				akland	ATT	Garret			
<u> </u>	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION			10d. INSIDE CITY		
اَۃُ	WV P	reston	Tu	nnelto	n		LIMITS?			
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF			
	P.O. Box 116				21	6444	US			
FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC		IC ORIGIN? (Specify Yes		E American Indian,		
BYF	1 Never Married 2 Married 3 Widowed 4 X Divorced	FORCES? 1 TYES	2 XNO	It yes, spe	cify Cuben, Mexican 2 X NO Specify.	, Puarto Rican, etc.)	Bied	k, White, atc.		
3	15. DECEDENT'S EDUCAT	ION	16a. DECEDENT'S USU	IAL OCCUPATIO	N	16b. KIND OF BUS	INESS/INDUSTRY			
<u></u>	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use rel	done during mos lired.)	at of working					
COMPLETED	5		TRackman	n		Rat	ilroad			
5	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	AE (First, Middle, Maiden				
Č L	Henry	Nice				ne Greath				
ן מ	19a. INFORMANT'S NAME (Type/Print)	11200	10h MAILING 101	DESS (Same)		oute Number, City or Town				
2	Nellie Wagner				dsville,		_			
								Deer 1		
	20a. METHOD OF DISPOSITION  1 N Burlel 2 Cremetion 3 Remove		b. PLACE AND DATE OF DI metery, crematory or other i	olace)		DATE 20c. LOCATION — City or Town, State  6/5 Terra Alta, West VA				
	4 Donation 5 Other (Specify)		Pine Grove	7	ra Alta,	West VA				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	A \			D ADDRESS OF FAC					
1	b- Brokly, H-J	Memorial		32	wart Fune	eral Home i St., Oak	land MD	21550		
CEMILICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Conges DUE TO FOR AS A KLOOS	A CONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):	Cor	t f.	arlune voscu	onset and Deal 10 yr cular dir. 15 yr.			
MEDICAL	PART ii. Other significent conditions of	contributing to death i	out not resulting in the	ne underlying	ceuse given in i	Part I. 24a. WAS AN PERFOR	MED?	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO		
PHISICIAN	25. WAS CASE REFERRED TO MEDICAL			06.00	ACE OF DEATH (Ob-					
2	EXAMINER?	IOSPITAL:	QI	WER:	ACE OF DEATH (Che					
-	27. MANNER OF DEATH	26e. DATE OF INJURY	petient 3 U DOA 4		5 Residence					
70	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 Y	RK? ES 2 NO	26d. DESCRIBE HOW I	JURY OCCURED			
	3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Spe	f — At home, farm, stree cify)	t, factory, office		261. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLEIED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my know						s) end menner as stated.		
O BE C	29h SIGNATURE AND TITLE OF CERTIFIER	son 6	5 MO		29c. LICENSE NUM 0424	BER 4	29d. DATE SIGNED	3/95		
-	30. NAME AND ADDRESS OF PERSON WHO	A VOTO	ATH (ITEM 27) (Type, Print) 9 U / 0.5	1//	04 E	State	54.	Terra Alta		
2	31. DATE FILED (Marith, Day, Year)  8 1995	38. REGISTRANS SIGN	harball				· · · · · · · · · · · · · · · · · · ·	WV 267		

		- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le.	st birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HBS			
			213-82-3295	1XXM 2 □ F	57	YRS.	MONTHS	DAYS	HOURS	MIN.			
binods			9e. FACILITY NAME (If not institution, give				9h CIT	C TOWAY	R LOCATI	ON OF I			
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1. 2.		6	RESIDENCE OF DECEDENT		<del></del>			) T L V I	1K 31	KIN			
Sec		DIRECTOR	10e. STATE 10b. COUN	TY		10c. CIT	Y, TOWN	OR LOCAT	ION				
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ne.		A I	10e. STREET AND NUMBER					101	. ZIP CODI	E			
-0020 ing physician. the bunal-transit permit. Pages 1,		FUNERAL	10261 NOLAN	DRIVE					20	850			
o sician al-tra		5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HI										
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5-C	- 1		3 Widowed 4 Divorced										
21 afte		COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION fe completed)	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N st of workin	107			
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;, MARYLAND 21215-0020 be retained by the hospital or attending physician. ge 5 should be detached for use as the burial-tran	- Comp	- 1	17. FATHER'S NAME (First, Middle, Last) ABRAHAM OHAN.	A					18. MOTH	OLI			
R bud b	8	BE	19a, INFORMANT'S NAME (Type/Print)		1 40		400000						
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Page al dire	190	ı	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		Dillio	22.	NAME AN	D ADDRES	SS OF F			
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d In by	medical	Į	23. PART I. Enter the diseases, or ahock, or heart failure	Complications the List only one cau	it caused the de use on sech line	eth. Dor	ot enter	tha mo	de of dyi	ng, su			
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within 24 within 24 pletely fills			disease or condition										
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eath certifica attending phy	or of		resulting in death) LAST		(en no n conce	JOENOE OF	<i>'</i> -						
S, P e death the atter Mental	2 6	CERIIFICATION		d		-							
RECORDS, P.O. BOY requires that the death certificate be seen signed by the attending physician of Health and Mental Horiene prior in			PART II. Other significent condition	na contributing to	death but not r	asulting i	n the ur	ndarlying	ceuse g	jiven ir			
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	or ite		1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		5 🗆 Re	sidence			
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ONG PH After thi	-		1 Natural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	oy, rowry		M	1 🗌 Y		] NO			
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	1 28 T		4 Homicide determined		(0,000))								
	item item		29e. CERTIFIER (Check only	SICIAN: To the best of	my knowledge, de	ath occurre	d at the t	lme, date	and place.	end du			
THE HOSPITAL THE FUNERAL	ANT: If item 28 is	5	one)	ER: On the beste of e									
TO THE HOSPIT TO THE FUNERA be filed within 7	RITA		29b. SIGNATURE AND TITLE OF CERTIFIE					T	29c. LICE				
0 THE 90 See See See See See See See See See Se	MPOR			Rapiro 4	n			-		35			
FFE	E E	²   <b> </b>	30. NAME AND ADDRESS OF PERSON WI			4 27) (Type,	Print)						
3			DEENA J. SHAP.		_	O COM		2017	- ALM	=			

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

MAY 30 1995

1. DECEDENT'S NAME (First, Middle, Last)

MAXIM

95 18614 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 1995 1:35 A . MAY 7. DATE OF BIRTH (Morth, Day, Year)
MAY 15, 6. BIRTHPLACE (State or Foreign MINN. MOROCCO 1938 CATION OF DEATH 9c. COUNTY OF DEATH SPRING MONTGOMERY 10d. INSIDE CITY LIMITS? 1 - YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 20850 CANADA ENT OF HISPANIC ORIGIN? (Specify Yes or No— Cuben, Mexican, Puerto Ricen, stc.) NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY working BEAUTY SALON MOTHER'S NAME (First, Middle, Meiden Sumerne) SOLIKA MALKA umber or Rural Route Number, City or Town, State, Zip Code) E - ROCKVILLE, MARYLAND 20850 29c. LOCATION -- City or Town, Slate 5/25 ADELPHI, MARYLAND DDRESS OF FACILITY
XY-GOLDBERG MEMORIAL CHAPELS, INC. CKVILLE PIKE - ROCKVILLE, MD. 20852 of dying, such as cardiac or respiratory arrest, Approximata **Onset and Death** a DAYS 3YEARS LEROSIS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? sae given in Part I. 1 TES 2 PAO OF DEATH? 1 YES 2 NO INCERTAIN ☐ Residence 6 ☐ Other (Specify) 26d. DESCRIBE HOW INJURY OCCURED 2 NO 26f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) place, end due to the cause(e) end manner as stated. occured at the time, date end place, end due to the ceuse(e) end menner ee stated. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

5/25/95

MO 20895

D 35336

KENSINGTON

12

HAIR DRESSER BEAUTY S/

ABRAHAM OHANA

SOLIKA MALKA

EVELYNE OHANA (WIFE) 10261 NOLAN DRIVE - ROCKVILLE, MARY)

MT. LEBANON CEMETERY 5/25 ADELPI

DANZANSKY-GOLDBERG MEMORIA 1170 ROCKVILLE PIKE - ROCK

George

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within real hours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit.		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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ING PHYS	After this (	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	marked
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ELIZABETH CLAIRE **OVERATH** 28 1995 11:00AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig Country) 1 M 2 W HOURS 218-82-1446 45 SEPT. WASH. D.C. Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES GENERAL HOSPITAL CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. PRINCE GEORGES KETTERING 1 X YES 2 NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12608 DARLENEN ST. 20772 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 □ YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 12 ASSEMBLY PRIVATE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) FRANCIS OVERATH X. BE CLARICE POTTS 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 FRANCES MADISON ST., SUTHERLAND HYATTSVILLE, MD. 20781 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State GATE OF HEAVEN CEMETERY 6/1 Donation 5 Other (Specify) SILVER SPRING. MD. 21. SIGNATURE OF FUNERAL SERVICE LIDENSEE 22. NAME AND ADDRESS OF FACILITY M00091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Syndrome Adult Respiratory Distress 2 weeks reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): septicemia UNK. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING megacolon with gangrene bowel UNK. CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa reaulting in death) LAST PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY tailure 1 YES 2 NO OF DEATH? Gastrointestinal hemorrhage 1 TYES 2 TNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO I UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only of HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 🗍 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. (Check only one) 2/ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 28/95 ~ r. c 03955 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4850 Forbes Blvd. Lanham, Md. 20706 C- Mallar m.O 32. REGISTRAR'S SIGNATURE 31 1995 DHMH-16 Rev 1/89

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BALTIMORE, MARYLAND 21215-0020

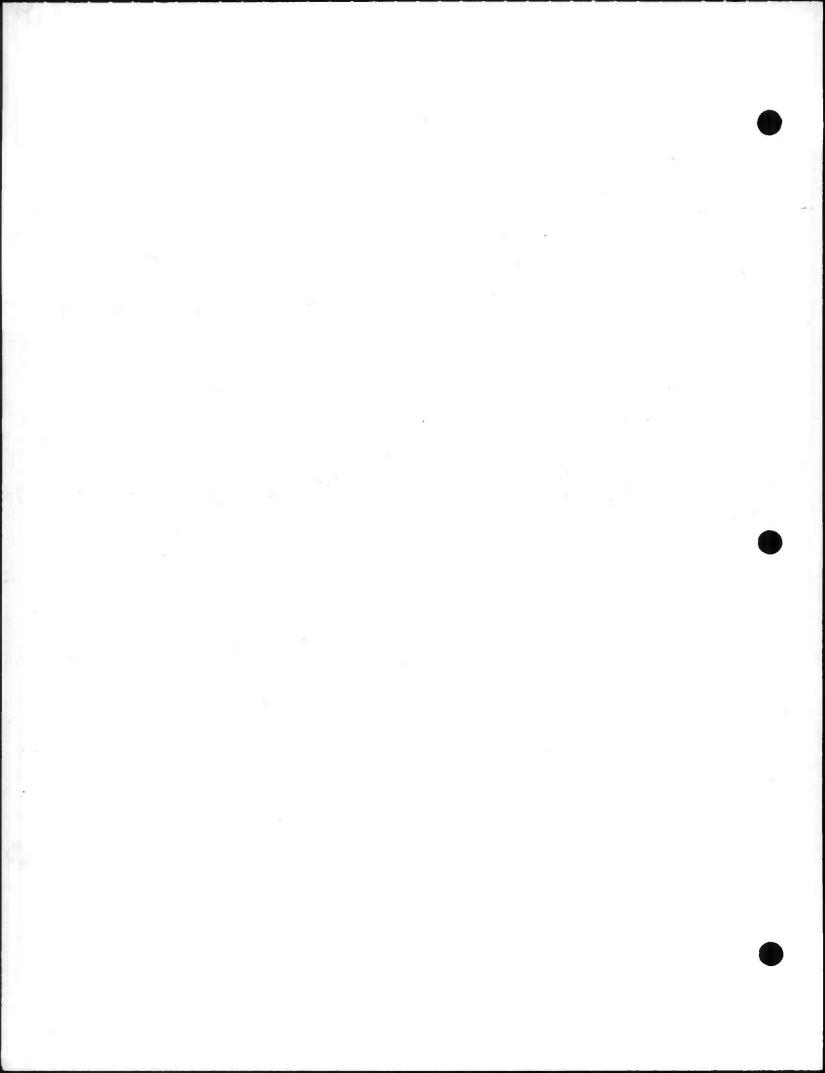
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last)		63 - 13 -		- 11	2. DATE OF DEATH		3. TIME OF DEATH				
	Pora		OCHE	ROVI	ICH	May 23		1035 P M				
	4. SOCIAL SECURITY NUMBER 220-41-8455		(In yrs. last birthday) 75 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreign				
	9e. FACILITY NAME (If not institution, give st		/5 YRS.			Aug 25, 19	19 Rus	Sia				
œ					OR LOCATION OF DE	ATH	9c. COUNTY OF I					
DIRECTOR	Shady Grove Hospi	tal		Rockvi	.TTe		Montgom	ery				
RE	10e. STATE 10b. COUNTY			Y, TOWN OR LOCA			10d. INSIDE CITY					
		omery	Si	lver Spr	ing			VES 2 NO				
FUNERAL	100. STREET AND NUMBER	4		10	f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
JNE	245 Amberleigh Dr	1VE  12. WAS DECEDENT EVER II	NII C ADMED	12 480 05	20904		US					
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Mexican		Blac	E — American Indian, k, White, etc.				
ВУ	3 Widowed 4 Divorced			I I TES	NO Specify:		Spec	ite				
TED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	(Give kind of a	USUAL OCCUPATI	ON ost of working	166. KIND OF BUS		100				
LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us		•							
COMPLET	17. FATHER'S NAME (First, Middle, Last)	5+	Doc	tor	10 MOTHERIO MAN	Medic						
	Lazar Levin				1115	(Unknown)	Surname)					
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Street		oute Number, City or Town	n, State, Zip Code)					
5	Vladimir A. Osher	ovich						20904				
	20s. METHOD OF DISPOSITION 11/2 Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Complete Cremetton of other place)											
	4 Donestion 5 Other (Specify)  Judean Memorial Gardens 5-25 Olney MD  21. SIGNATURE OF FUNERAL SERVE LICENSEE  22. NAME AND ADDRESS OF FACILITY											
	No Al	7				Funeral Di	rection					
_	Elen Act			1091	Rockville	Pike Ro	ckville	MD 20852				
	23. PART I. Enter the diseases, or constant shock, or heart fellure. L	int only one cause on e	d the death. Do n ach lina.	not enter the mo	de of dying, auch	as cardiac or respi	ratory arrest,	Approximata interval Between				
	immediate cause (Final disease or condition resulting in death)  Severe metastatic (according											
ŀ	resulting in death)	DUE TO (DR AS /	CONSEQUENCE OF	D:	mayer			Zwale				
Z		ascilor						2 webs				
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	ŋ: 				7,000				
5	CAUSE (Diseese or injury	DUE TO OR AS A	CONSEQUENCE OF	indi ce				2000				
CERTIFICATION	that initiated events resulting in death) LAST	Left of	Ser II	hust.	Crowphi			Zonela				
	DADT ii Other significant conditions			(								
CAL	PART ii. Other algnificent conditions	contributing to deeth b	ut not resulting i	n the underlyin	g cause given in P	Part I. 24s. WAS AN A		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ED						1 🗆 YES 2	₽ NO	OF DEATH?				
Σ.	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	SUNOL	UNCERTAIN			1 YES 2 NO				
Ä	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		OTTOERIANT							
PHYSICIAN: MEDIC		HOSPITAL: 1   Inpatient 2   ER/Outp	etient 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence 6	☐ Other (Specify)						
H	27. MANNER DF DEATH  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI		URY AT	28d. DESCRIBE HOW IN	JURY OCCURED					
B	2 Accident Investigation				rES 2 ND							
8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	treet, factory, offic	•	281. LOCATION (Street at City or Town, State)	nd Number or Rural F	loute Number,				
9	29a. CERTIFIER											
COMPLETED		IAN: To the best of my knowl : On the besis of examination						and manner or stated				
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMB		29d. DATE SIGNED					
B	many	den	P		カマ3	445	► May	24 //9=				
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE		Print)	21	7/-	10 1	1/17/5				
	Mary Fan	9 m	121	congres	s, on af la	#310	Rocker	lle, m/20852				
	MAY 31 1995	32. REGISTRAR'S SIGNA	ATURE									
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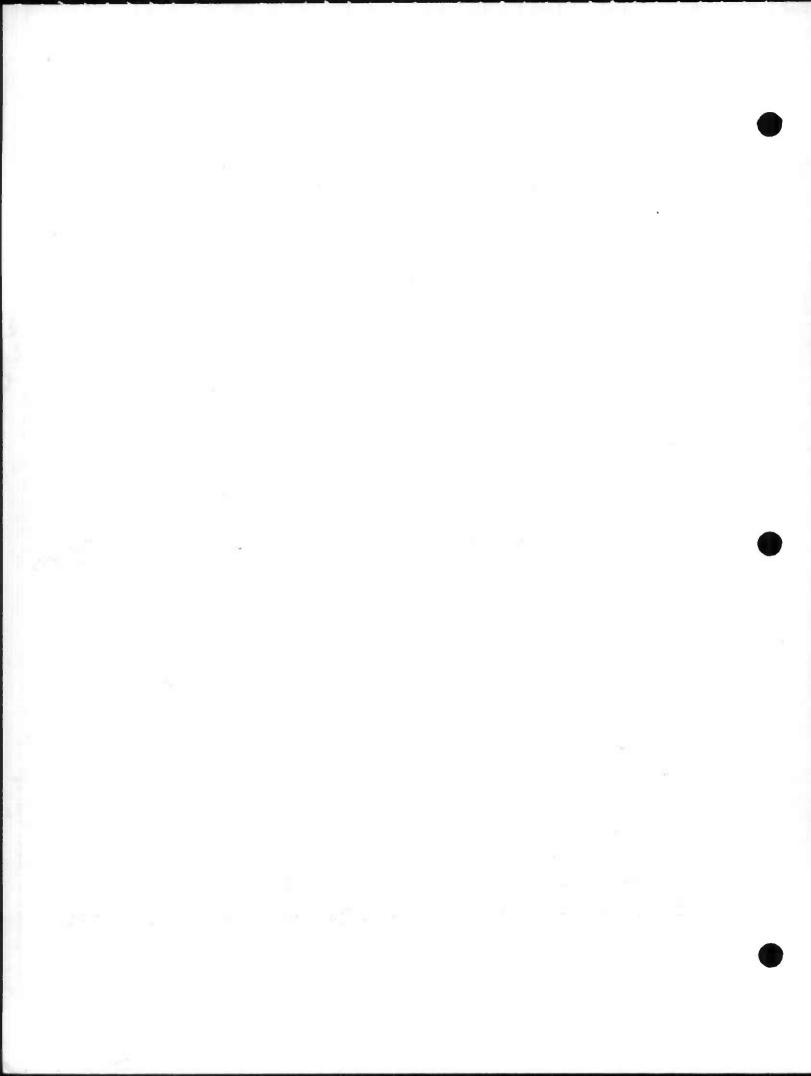
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FOR STATE REGISTRAR	STATE (	OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL	HYGIENE REG. NO.
GILLIS	С.	OWINGS	2. DATE O	29 DAY 199

	1. DECEDENT'S NAME (First,	100	С.	OWI	NGS					2. DATE OF DE		199	YEAR	3. TIME OF DEATH 7:34 A
	4. SOCIAL SECURITY NUMBER 577 - 26 - 8830	BER	5. SEX 1 [2] M 2 [ F	6. AGE (In yrs. la.		IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BH (Month, Day, NOV 4	TTH Ybar)	908	8. BIRTH	PLACE (State or Foreign
OR	90. FACILITY NAME (II not in 5 900 DAMAS)	CUS R	treet and number)					ERSBI			, 15	9c. COU	NTGON	EATH
2	RESIDENCE OF DEC	10b. COUNTY	,		100 CIT	ZOMBI (	OR LOCAT	1011						
DIRECTOR	MARYLAND		NTGOMERY			*	ERSB				٠			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 5900 DAMAS	SCUS	ROAD				101	zip cooi	0882					STATES
B	11. MARITAL STATUS 1 Never Merried 2 3 3 Widowed 4 Divo		FORCES? 1	IT EVER IN U.S. AF  YES 2 X WAR OR DATES	MED NO		If yes, sp	ecify Cube	n, Mexicar	IC ORIGIN? (Spe n, Puerto Rican,		or No-	14. RACE Black Speci	E — American Indian, c, White, etc.
유	15. DEC	EDENT'S EDU	CATION		CEDENT'S					16b. KIND	OF BUS	INESS/INC	DUSTRY	MILLIE
COMPLETED	Elementary/Secondary (0	y highest grade I-12)	College (1-4 or 5	H6e	Do NOT us	rork done e retired.) RMER	during mo	st of workin	g		FARM	1ING		
BE CO		DWINGS	SR.					ELIZ	ABET		RO	YER		
6	194. INFORMANT'S NAME (7) ANNA MARY	OW ING	S	5	900 [	AMA:	S (Street a	ROAI	or Rural A	AITHERS	BUR(	Store, Zip	ARYL/	AND 20882
	20e. METHOD OF DISPOSITI  1 M Burlel 2 Crematio 4 Donation 8 Other	n 3 🗆 Reme	oval from State	20b. PLACE cemetery, cre	AND DATE OF OR CARM	her place)		me of TERY	6/1	1			City or To	NN, State
8	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE	1. 1.1.	/	22.	NAME AN	O ADDRES	S OF FAC			-		20882
	7/7	7/	1 / 1000	- Color		P	.0.	BOX !	038	LAYTO	NSV	LLE	MAI	RYLAND
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart tellure.	a. No	ise on eech line	92F	~>					r reapin	atory an	rest,	Approximate Interval Between Onset and Death
ATION	Sequentielly list conditi if any, leading to immedicause. Enter UNDERLY	diete	b. OUE TO	(OR AS A CONSE	DUENCE OF	·):								
CERTIFICATION	CAUSE (Disease or Inju that initiated events resulting in deeth) LAS		DUE TO	(OR AS A CONSE	OVENCE OF	):								
	PART II. Other algolfica	nt condition	a contributing to	death but not	eaulting i	n the ur	deciving	COURS C	Iven In I	Part I 24a I	MO AN A	UTOPSY	245	WERE AUTOPSY FINDINGS
MEDICAL										,	YES 2	AED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO U		RIBUTE TO CA		TH YE			UNC	ERTAIN					1 YES 2 NO
2	EXAMINER?		HOSPITAL:		Т	OTHE	R:							
PHYSICIAN:	27. MANNER OF DEATH  Natural 5	Pending	28e. DATE OF (Month, D	INJURY	28b. TIME	E OF	28c. INJI WO			8 Other (Spec 28d. DESCRIBE		JURY OC	CURED	
TED BY	3 Suicide 8	nvestigation Could not be determined	28e. PLACE O building,	F INJURY — At ho	me, farm, a	treet, tact			NO	28t. LOCATION City or Town	(Street and	nd Number	or Rural R	oute Number,
COMPLET			CIAN: To the best of											
8		A	H: On the besis of e	xemination end/or	Investigation	n, in my c	pinion, d	eath occun	ed at the t	lime, date end pl	ace, and	due to th	e cause(s	end manner as stated.
BE	296. SIGNATURE AND THILE	Tal	_						1356					(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO		SE OF DEATH (ITE	W 27) (Type,	Print)	Da.	0	L~6	1, MAR	7.			0032
	31. DATE FILED (Month, Day,	1995	92. REGISTRA	B'S SIGNATURE	14						,			



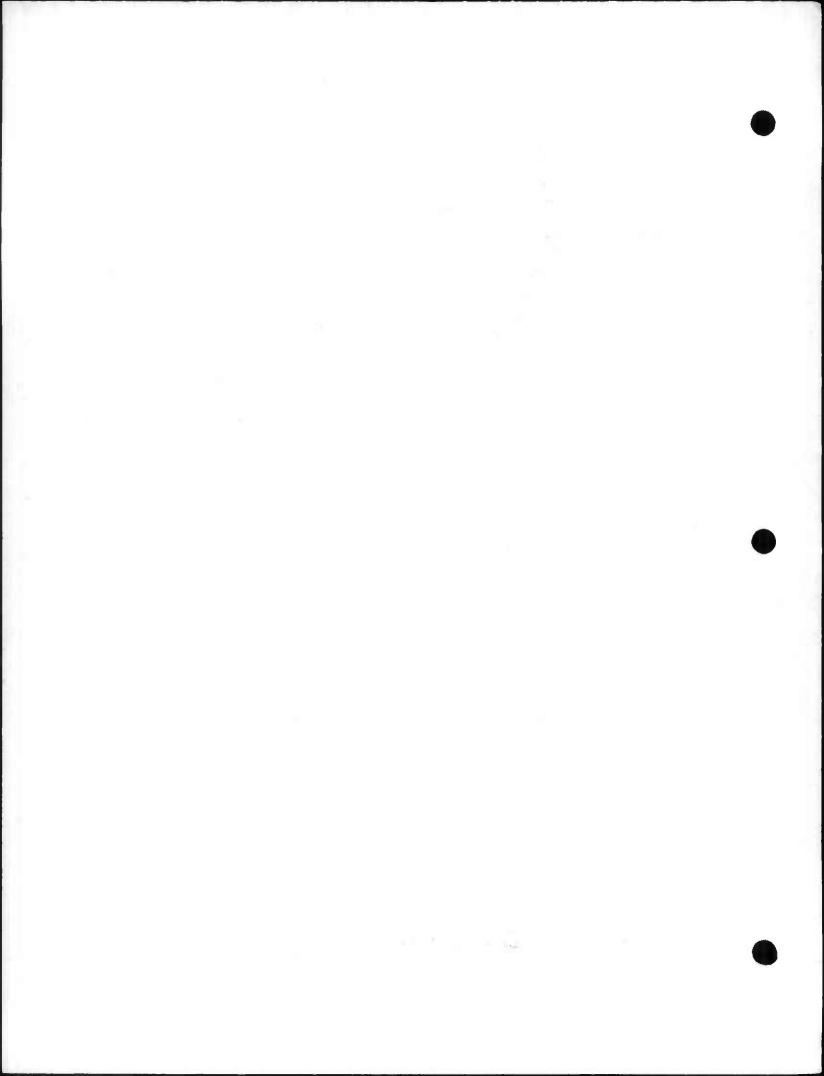
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4	The
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DIVISION	OR ATTENDING PHY
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPAI CERTIF	RTMENT	OF HEALT	H AND I	MENTAI	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	OF DEATH	W V	EAR :	3. TIME OF DEATH
	JEFF PER  4. SOCIAL SECURITY NUMBER	RY OSBORNE					5	- 28	3 19	95	3:28 a M
	226-30-4734	1 5km 2 □ F 67	rs. last birthday) YRS.	IF UNDER	DAYS HOUR	DER 24 HRS. S MIN.	7. DATE (Month	OF BIRTH 1, Day, Year) 1-23-1	927	Country)	IRGINIA
OR	53. FACILITY NAME (If not institution, give 5325 SIXTY F				ARSON				9c. COUNTY		MICO
<u>ا تا</u>	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	TY .	10c. CI	Y TOWN O	R LOCATION						Od. INSIDE CITY
DIRECTOR	MD. W	ICOMICO			ONSBU	RG I				- 1	LIMITS?
	10a. STREET ANO NUMBER			2 211(0	10f. ZIP C				10g. CITIZE		AT COUNTRY?
ER	5325 SIXTY	FOOT RD.			21	849			U	. S . I	A
BY FUNERAL	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	MD	11	MAS DECENDENT yes, specify Co	sban, Maxica	n, Puarto F	? (Specify Yes Rican, atc.)	or No.— 14	Black, Specify:	American Indian, White, atc.
	15. OECEDENT'S EDI (Specify only highest grad	UCATION 16	a. DECEDENT'S	USUAL OC	CCUPATION furing most of wo	el fore	16b.	KIND OF BUS	SINESS/INDUS	TRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT L	se retired.)		rking		WADA	T AND	Q171	
MP	7 17. FATHER'S NAME (First, Middle, Last)		MEC	HANI					LAND	CUI	P
BE CC	WASH OSBO	RNE						Middle, Maiden SBORN			
2	19a. INFORMANT'S NAME (Type/Print)  EARLINE MYRA	OSBORNE			(Street and Num						MD.21849
	20a. METHOD OF OISPOSITION  1  Burlel 2  Cremation 3  Rer 4  Donation 5  Other (Specify)	novel from State 20b. PL cemeter M	ACE AND DATE  Y, Crematory or A  EADOW	of disposi	TION (Name of E CEM)	ETERY	y 6-		CATION — CH		
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE .	//	22. 1	NAME AND ADD	RESS OF FA	CILITY				
	1 Kiptt	1. Come			BOUN	DS FI	INER	AT, HO	ME.S	AT.TS	SBURY, MD.
4	23 PARTI. Enter the diagram, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Mutations that caused the list only one cause on each	line.	_ (	bwll		h aa card	liac or reapi	ratory arrea	t,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.  DUE TO (DR AS A CO  C.  DUE TO (DR AS A CO  d.	NSEDUENCE C	F):							
PHYSICIAN: MEDICAL	PART II. Other significant condition						_	24a. WAS AN PERFOR 1 VES 2	MED?	6	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 ND
AN	25. WAS CASE REFERRED TO MEDICAL	TONIKIBUTE TO C	AUSE O	r DEA	TH YES	-				<u> </u>	
2	EXAMINER?	HOSPITAL: 1   Inpetiant 2   ER/Outpetie	et 3 □ 004	OTHER		/					
H	27. MANNER OF DEATH	28a. DATE DF INJURY	28b. T#	E OF	28c. INJURY AT			CRIBE HOW II	NJURY OCCUI	RED	
ВУР	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN .	JURY	WORK?	⊇ □ ND					
	3 Suicide 8 Could not be 4 Homicide detarmined	26a. PLACE DF INJURY — building, etc. (Specify)	At home, farm,	atreet, facto	ory, offica		281. LOC	ATION (Street a or Town, State)	and Number or	Rural Roo	ute Number,
COMPLETED		SICIAN: To the best of my knowledg									and manner as stated.
- 4	290. SIGNATURE AND TIPLE OF CENTRE	ER			29c. L	ICENSE NUI	MBER		29d. DATE S	IGNED (A	Wonth, Day, Year)
O BE	Mel	mu)				1260	778		D 5	-3	0-95
-	30. NAME AND ADDRESS OF PERSON W		(ITEM 27) (Type	St.	S	lish	1	11)			
	31. DATE FILED (Month, Day, Year)	32 AEGISTRAR'S SIGNATU	P			(	7				
- 1	MAY 3 0 199!	) Name minerale	and all			-					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

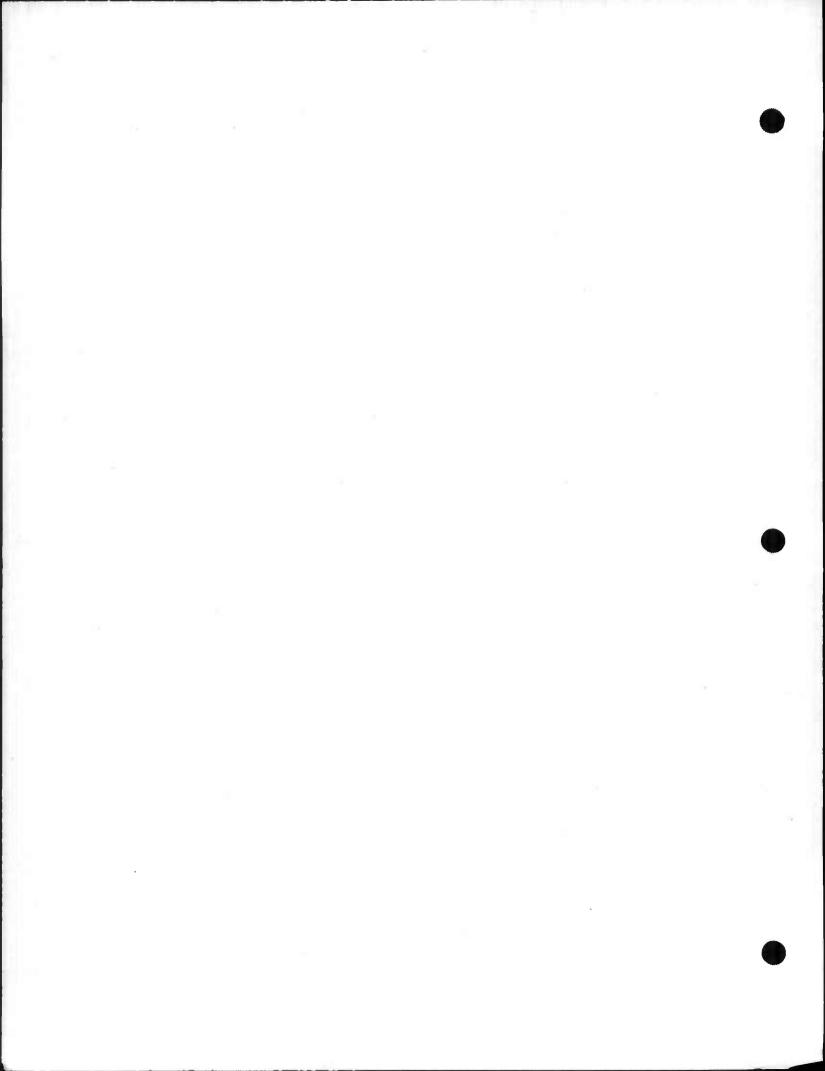
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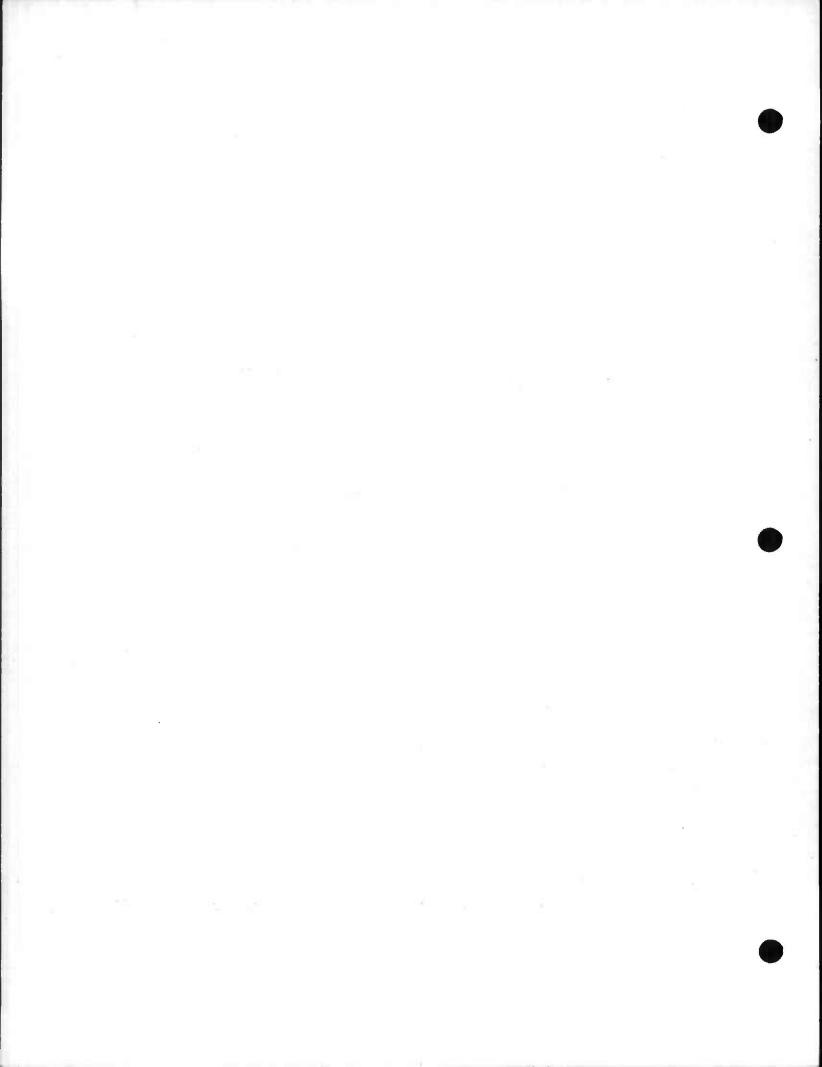
	REGISTRAR		CERTIF	CATE	F DEATH	REG.	NO.		
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEAT			3. TIME OF DEATH
	Florence Soon Young	Rhee Parl	K			May :	2.2 DAY	1995	1:10 P M
	4. SOCIAL SECURITY NUMBER 5. SEX		yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7 DATE OF BURY		-	NPLACE (State or Foreign
	578-48-4239 1 D M		85 YRS.	MONTHS DA		(Month, Day, Yei	1010	Count	(ry)
	9e. FACILITY NAME (If not institution, give street end nu		U.J. Ins.						orea
~		mber)	1		YN OR LOCATION OF D	EATH	9c. CO	UNTY OF E	DEATN
0	Holy Cross Hospital		1	Silv	er Spring		Mo	ntgon	nery
5	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY								
DIRECTOR			- 1	, TOWN OR LO					10d. INSIDE CITY LIMITS?
	Maryland Montgomery	7	Si	lver S	pring				1 YES 2 NO
AL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CI	TIZEN OF	WHAT COUNTRY?
H	1105 Highland Drive				20910			USA	
FUNERAL	11. MARITAL STATUS 12, WAS	DECEDENT EVER IN	U.S. ARMED	13. WAS	DECENDENT OF HISPAI	NIC OBIGINS (Specif	. You or No	-	E — American Indian,
II.	1 Never Married 2 Merried FORC	ES? 1 TYES	2 ENO	If yes	, specify Cuban, Mexica	in, Puerto Rican, etc	.)	Blac	k, White, etc.
B	3 Wildowed 4 Divorced	3, GIVE WAR OR DAT	ES	1 📋	YES 2 NO Specifi	γ:		Spec	orean
۵	15. DECEDENT'S EDUCATION		16a. DECEDENT'S	HELIAL OCCIA	ATION	Lest White or			.o.roun
E	(Specify only highest grade completed)		(Give kind of w	ork done during	most of working	166. KIND OF	BUSINESS/II	NDUSTRY	
ا ڐ	Elementary/Secondary (0-12) College	(1-4 or 5+)		rarian		7 .1			
Σ			PID	Larran			ary of	Con	igress
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Me	iden Surneme)		
BE	Won Min Rhee				Won Mo	Hahn			
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	et end Number or Rural i	Route Number, City or	Town, State, 2	(ip Code)	
임	Stanley S. Park				Avenue, S				rsey 07078
	20e, METHOD OF DISPOSITION 1 Burlet 2 Cremetton 3 Ramoval from 2	20h F	PLACE AND DATE O				LOCATION -		
	1 🖾 Buriel 2 🗆 Cremetion 3 🗆 Ramoval from :	State gerner	tery cremetery or ou	per place)	netory				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		TO DINCE			3/20 Bi	entwo	oa, r	laryland
	· 4. W 11	^		118	00 New Ham	nchire A	-Kina	Ld1 F	uneral Home
	Wine of the	Luas		Sil	ver Spring	. Marvla	nd 20	1904	
	23. PART I Enter the disease, or complicati	ona that caused	the death. Do n	ot enter the	mode of dving suc	h sa cardiac or r	eniratory a	TOO!	Approximata
	shock, or heart failure. List only	one cause on aac	ch line.		,,,,,,,,,		oupmatory a	rreat,	interval Between
	IMMEDIATE CAUSE (Final disease or condition	00 0							Onset and Death
ŀ	resulting in death)	Anny							48 horris
		DUE TO (OR AS A	CONSEQUENCE OF	):					
z	C b	Dear	is						2 helps
일	Sequantielly list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	jt:	A				
8	cause. Enter UNDERLYING	inverter	Lealy	on G	dule				21.000
	CAUSE (Disease or injury that initiated eventa	DUE TO OR AS A							- und
CERTIFICATION	resulting in death) LAST								
빙┃	- a								
7	PART II. Other aignificent conditions contribu	iting to deeth but	t not resulting in	the underi	ying ceuse given in	Part i, 24a. WA	AN AUTOPSY	24b	. WERE AUTOPSY FINDINGS
EDICAL	chimi reval /	uture				1	FORMEO?	_	AMILABLE PRIOR TO COMPLETION OF CAUSE
요	A	1	\ n. 01			1 U YE	S 2 KNO		OF DEATH?
Σ	And perimed	Kemonh			<b>—</b>				1 TYES 2 NO
Z	DID TOBACCO USE CONTRIBUTE			S   NO		1			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF DEAT		ne)				
S		lent 2 - ER/Output		OTHER: 4  Nursing (	iome 5 🗆 Residence	6 Other (Specify)			
ξI		DATE OF INJURY	28b. TIME	OF 28c.	INJURY AT	28d. DESCRIBE NO	W INJURY O	CCURED	
	1 Pending	Month, Day, Year)	INJU	4.4	WORK? YES 2 NO				
ă	280	PLACE OF INJURY -	- At home, farm, st	reet, fectory, o	ffice	281. LOCATION (St	net and Numbe	er or Russi (	Doubs Mumber
ᆲᅦ	4 Nomicide 8 Could not be determined	building, etc. (Specif)	1)	,		City or Town, S		or or noral r	TOUR NUMBER
	20- OFFICE								
١ ا	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the	best of my knowled	dge, death occurre	d at the time,	late end place, and due	to the cause(s) end	manner ee st	ated.	
COMPLETED	one) 2 MEDICAL EXAMINER: On the b	eals of examination (	end/or investigation	ı, In my opinio	n, death occured at the	time, date end place	, end due to	the cause(s	end manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	$\wedge$			29c, LICENSE NUM			_	
	MAN VR.				- A		290. UA	/	(Month, Day, Year)
2	30 NAME AND ADDRESS OF BERSON WAYS SOURCE	TO CAUSE OF ST	AL STEAL CT		17 DO 6	00		2000	75
	30. NAME AND ADDRESS OF PERSON WNO COMPLET		N (ITEM 27) (Type,	Print)	/	1 10			
	Mark > Kose	n, Mo		20	luer Spr.	ng/14			
		EGISTRAR'S SIGNAT	URE					-	
	MAY 30 1995 Jul	in Skudsor	Mardall						
	1000		V						



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	1 - STATE REGISTRAR	STATE OF MARY			HEALTH AN	D MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Lat. JOAN MARTIN	GRIBBIN 1	PELTIN				TE OF DEATH	1995	YEAR	3. TIME OF DEATH 12:15 PM M
	4. SOCIAL SECURITY NUMBER 212-30-9831	5. SEX 6. AG	E (In yrs. lest birthday) 62 YRS.	MONTHS DAY		, (Mo	e of Birth oth, Day, Year) . 19, 1	032	Country	
	Se. FACILITY NAME (If not institution, give	re street and number)		9b. CITY, TOW	N OR LOCATION O		. 19, 1	9c. COUN	_	yland EATH
DIRECTOR	2706 Snowbird		#3	Sil	ver Spri	ng		Mon	tgon	nery
IREC	10a. STATE 10b. COU	NTY		Y, TOWN OR LO						10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	tgomery	5	ilver S	pring			10a, CITIZ	ZEN OF W	1 X YES 2 NO
FUNERAL	2706 Snowbird Te				20906				US	
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	It yes,	DECENDENT OF HIS specify Cuban, Me (ES 2 X NO Sc	xican, Puert	MN? (Specify Yes o Rican, etc.)	or No-	14. RACE Black Specifi	- American Indian, White, etc. by: White
TED	15. DECEDENT'S E (Specify only highest gri	ade completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done during		10	Sb. KIND OF BUS	INESS/IND	USTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		s Analy	st		N.I.	н.		
	17. FATHER'S NAME (First, Middle, Last)  John J. Martin				70.00		, Middle, Maiden	,		
BE (	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Ru		B. Mart		Code)	-
2	Michael Raymond	Gribbin			amrock R					d 21014
	20a. METHOD OF DISPOSITION  1 N Burlal 2 Cremation 3 Re  4 Donation 8 Other (Specify)	emoval from State	ob. PLACE AND DATE emetery, cremetory or d lary land	of disposition other place) Vationa	(Name of	ark 5	/26 T 211	CATION — C	Mars	wn, Siete
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	)	22. NAME	AND ADORESS OF	FACILITY	lines-Ri	nald	i Fu	neral Home
	Indien 1	· Jun h		Sil	00 New H ver Spri	ng, M	laryland	1 20	904	
	23. PART I. Enter the diseases, of ahock, or heart fellur iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Adus ca	each line.						)	Approximate Interval Between Onset and Daeth
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	с	B A CONSEQUENCE O							
SERTIF	that initiated events resulting in death) LAST	d	A CONSEQUENCE O	<del>F</del> ):						
AL	PART II. Other significant condition	one contributing to death	but not resulting	in the underly	ring ceuse givan	in Part I.	24a. WAS AN A		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC							1 - YES 2	NO		COMPLETION OF CAUSE OF DEATH?
N	DID TOBACCO USE CON	TRIBUTE TO CAUSE	OF DEATH Y	ES   NO	☐ UNCERT	AIN 🗆				1 YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	26. PLACE OF DEA	OTHER:						
PHYSICIAN:	27. MANNED OF DEATH	t Inpetient 2 ER/O	Y 28b. TIR		iome 5 Residentification   Transfer   Section   Transfer   Transfe		ner (Specify) ESCRIBE HOW IN	JURY OCC	URED	
ΒY	t Netural 5 Pending 2 Accident Investigatio	n		M 1[	YES 2 NO					
COMPLETED	3 Suicide 6 Could not 8 4 Homicide determined	building, atc. (S)	RY — At home, term, pecify)	street, factory, o	Mice	28t. LC	CATION (Street at by or Town, State)	nd Number (	or Rural A	loute Number,
APLE		YSICIAN: To the beat of my known								
	2 MEDICAL EXAMI	INER: On the besis of examine	lion and/or investigation	on, in my opinio			te and place, and			
TO BE	Lorge	a Spor	D MM		29c. LICENSE	3083		29d. DATE	2/S	(Month, Day, Year) 1198
	Dr. George A.		7 Medical		, #300,	Rocky	ville, l	MD 2	0850	)
	MAY 30 1995	32. REGISTRAR'S SH Julia d'Iurstian	Raviall							



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DIVISION OF VITAL RECORDS,	
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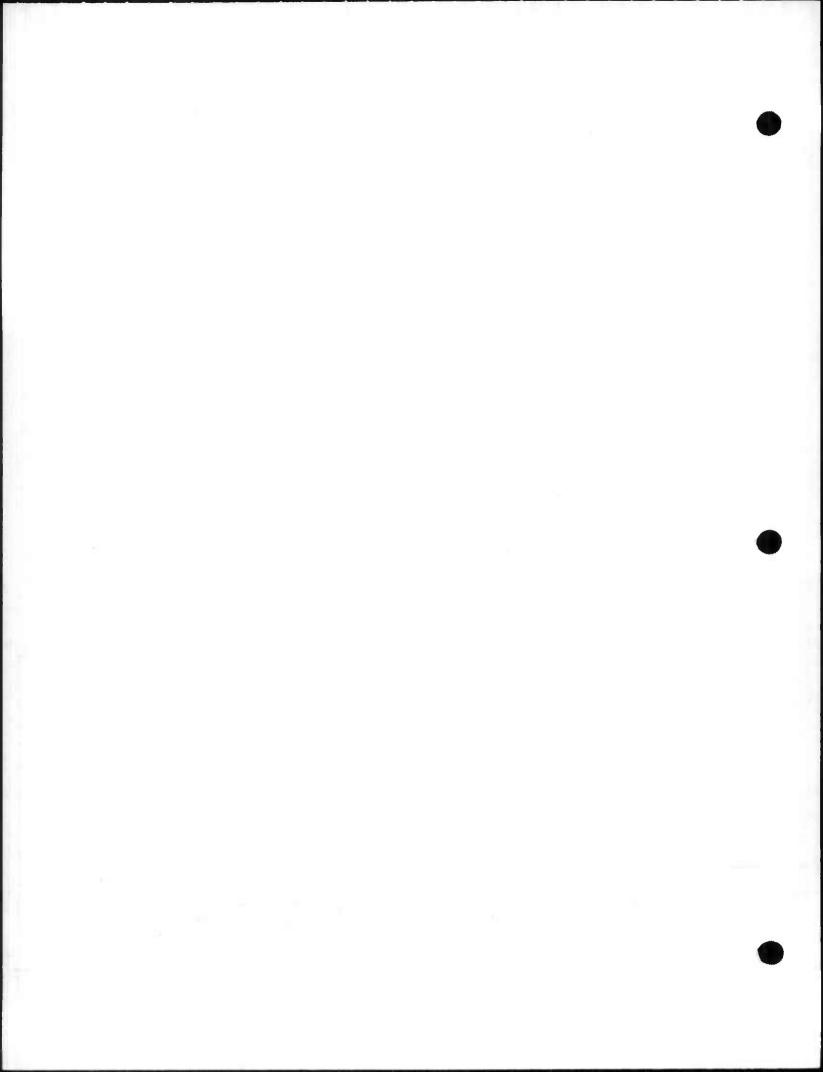
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfled at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - STATE OF MARYL REGISTRAR		ENT OF HEALTH A	ND MENTAL HYGIEI		
	1, DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	DAY YEAR	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. last birthday) IF U		May 26, 1		3:30 p. m
		MONT	NDER 1 YEAR IF UNDER 24 HB DAYB HOURS II	(Morith, Day, Year)	Co	RTHPLACE (State or Foreign untry)
	9e. FACILITY NAME (If not institution, give street and number)	0.3	CITY, TOWN OR LOCATION		1931 Mas	ssaachusetts
DIRECTOR	14729 Janice Drive		ockville		Montgo	
ÆC	10a. STATE 10b. COUNTY	10c. CITY, TOV	VN OR LOCATION			10d. INSIDE CITY
	Maryland Montgomery	Rockvi	i11e			LIMITS?
FUNERAL	10e. STREET AND NUMBER		101. ZIP CODE			F WHAT COUNTRY?
N	14729 Janice Drive  11. MARITAL STATUS  12. WAS DECEDENT EVER N	ullo apuen	20853			States
BY FU	1 Never Merried 2 Merried FORCES? 1 YES 3 Wildowed 4 Divorced	2 V NO	13. WAS DECENDENT OF HIT yes, specify Cuben, it I YES 2 NO	IISPANIC ORIGIN? (Specify Yo Aexican, Puerto Rican, etc.) Specify:	BI	ACE — American Indian, lack, White, etc. pecify: White
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUA	L OCCUPATION	16b. KIND OF BU	JSINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use retire				
MP	2	Legal Sec				orporation
8	17. FATHER'S NAME (First, Middle, Last)			'S NAME (First, Middle, Maide	n Surname)	
BE	Oscar Clifford Lowe			Porter		
2	Paul E. Ponton, Sr.			Rural Route Number, City or To		
	20g, METHOD OF DISPOSITION 20b	PLACE AND DATE OF DIS	POSITION /Name of	OATE 200.10	DCATION - City or	
	1 \( \tilde{\Omega} \) Buriel 2 \( \tilde{\Commatton} \) Cremetton 3 \( \tilde{\Omega} \) Removal from State (\$\text{gen}\$ \) 4 \( \tilde{\Omega} \) Donation 8 \( \tilde{\Omega} \) Other (\$\tilde{Specify}\$) \( \tilde{\Omega} \)	netery, cremetory of other ple ate of Heav	en Cemetery			ng, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS ( DeVol Funera	OF FACILITY		
	× 2.2.1 /2/				ithershu	rg, MD 20877
z		a the deeth. Do not en	iter the mode of dying,	such as cerdlec or resp	piratory arrest,	Approximets Interval Between Onset and Death
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	CONSEQUENCE OF):				
AL (	PART II. Other significent conditions contributing to death b	ut not resulting in the	underlying ceuse give		N AUTOPSY 2	4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDIC				1 _ YES		COMPLETION OF CAUSE OF DEATH?
×	DID TODA COO LICE CONTRIBUTE TO CALLED					1 - YES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE O 25. WAS CASE REFERRED TO MEDICAL	F DEATH YES 26. PLACE OF DEATH (Che		TAIN 🗆		
Sici	EXAMINER2  1 YES 2 NO HOSPITAL: 1   Inpetient 2   ER/Outp	OTH	IER:			
PHYSICIAN:	27. MANNER OF DEATH 280. DATE OF INJURY	26b. TIME OF	28c, INJURY AT	ence 8 Other (Specify)  28d. DESCRIBE HOW	INJURY OCCURED	
ВУ Р	Netural 5 Pending (Month, Day, Year)  2 Accident Investigation	INJURY	WORK?			
	- Decident	— Al home, farm, street,	factory, office	291. LOCATION (Street City or Town, State	end Number or Rura	il Route Number,
COMPLETE	29e. CERTIFIER (Check only Check only I) CERTIFYING PHYSICIAN: To the best of my knowledge.					
S S	One) 2 MEDICAL EXAMINER: On the beels of examination	end/or investigation, in n	ny opinion, death occured a	it the ilme, date and place, e	nd due to the ceus	e(s) end menner ee stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIED	U, m	29c. LICENSI 033	E NUMBER	29d. DATE SIGN	aG (Month, Pay, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	e Philip	In Oh	In. rs	20837
	31. DATE FILED (Month, Day, Yber)  32. REGISTRAR'S SIGN.  JUN 01 1995  Julia Davele	ATURE ON Ravdall			))	



DIVISION OF VITAL RECORDS, P.O. BOX 68760  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buniar be filed within 72 hours after death with the State Dest. of Health and Menial Hygiene prior to bunial, cremation, or removal.	
DIVISI E HOSPITAL OR ATTEN E FUNERAL DIRECTOR: within 72 hours after	

_	REGISTRAR CERTIFICATE OF DEATH REG. NO.												
İ	1. DECEDENT'S NAME (First, Middin, Lest)  2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH												
1	Alonzo Perritt May 27 1995	M											
	4. SOCIAL SECURITY NUMBER  5. SEX  5. SEX  5. SEX  5. SEX  7. DATE OF BIRTH  1. DAYS  1. DAYS  1. DAYS	1											
СТОВ	98. FACILITY NAME (If not institution, give street and number)  99. CITY, TOWN OR LOCATION OF DEATH  90. COUNTY OF OEATH  91. CITY, TOWN OR LOCATION OF DEATH  91. CITY, TOWN OR LOCATION OF DEATH  91. CITY, TOWN OR LOCATION OF DEATH  91. CITY, TOWN OR LOCATION OF DEATH  92. COUNTY OF OEATH  93. FACILITY NAME (If not institution, give street and number)												
S S	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY												
DIRE	Maryland Prince Georges Suitland, MD												
ERAL	104. STREET AND NUMBER  3005 Jaywood Ave.  10747 U.S.A.												
BY FUNER	Tr. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 1 Yes 2 NO 1 Yes												
۵	black												
ETE	(Specify only highest grade completed) (Give kind of work done during most of working												
COMPL	Elementary/Secondary (0-12) College (1-4 or 5+) Butcher private												
ш	17. FATHER'S NAME (First, Middle, Last)  McKenzie W. Perritt  18. MOTHER'S NAME (First, Middle, Maiden Surname)  Ethel Lacey												
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Jaywood Ave. Suitland, MD												
	29a. METHOD OF DISPOSITION THE Burlat 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)												
	21. SIGNATURE OF FUNERAL SERVICE LICENSUM  22. NAME AND ADDRESS OF FACILITY 600 Kennedy St. NW.  Washington, D.C. 20011												
	X.1/1. HONOS												
	23. PART I. Enter the diseases, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition as SQUAMOUS CELL, LUNG CARCINOMA												
	DUE TO (OR AS A CONSEQUENCE OF):												
ON	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):												
RTIFICATION	cause. Enter UNDERLYING TITVER METASTASTS												
F	CAUSE (Disease or injury that initiated exempts DUE TO (OR AS A CONSEQUENCE OF):												
CERT	reaulting in death) LAST RESPIRATORY INSUFFIENCY												
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY ENDIN	GS											
DICAL	BONE METASTASIS  PERFORMED?  AMAILABLE PRIOR TO  COMPLETION OF CAUSE												
ME	OF DEATH?												
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗵												
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  COTHER:												
HYS	1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home   Residence 6   Other (Specify)												
ВУ РЬ	27. MANNER OF OEATH  1 X Netural 5 Pending 2 Accident Investigation  28a. DATE OF INJURY 28b. TIME OF INJURY WORK?  8:50p M  1 YES 2 X NO												
TED	3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) home 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) home												
MPLE	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) end menner as stated.    CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) end menner as stated.   CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and menner as stated.												
8	and productive his year or divide												
TO BE	1100mb 40km mp D43162 \ \rightarrow 6/1/95												
	Dr. Melvin Gaskins 2401 Georgia Av. N.W. Washington, D.C.												
	31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE												
	JUN 02 1995 Jalin Savidson Revolate												

Pages 1, 2, 3

permit.

use as the burial-transit

retained by the hospital or attending physician. 5 should be detached for use as the burial-tran

page 5 should notified

funeral director,

the filled in by the jon, or removal. medical

cremation, or

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Hygiene prior to attending physician

signed by the atter Health and Mental

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BALTIMORE, MARYLAND 21215-0020

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CERTIFICATION

MEDICAL

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b. SIGNATURE AND TITLE OF CERTIFIER

02 1995

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Moreon

132. REGISTRAR'S SIONADURE

Mula

MANADAMO

ML

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SHIRLEY ANN PEARSON MAY 995 8:59 M 4. BOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign (Month, Day, Year)

Iay 21 HOURS 424-60-0611 1 M 25 3 F 50 May 945 Alabama 8s. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Columbia Howard TYES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21044 5495 Cedar Lane Apt #707 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Ric 1 TES 25 3NO Specify: 1 Never Married 2 Married 3 Widowed 4 Divorced Black 16. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 6 Yrs Medical Assist. None 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Stone Bernice Russell 19a. INFORMANT'S NAME (Type/Print) (Sister) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Lillie Watson 5495 Cedar Lane, Apt#301, Columbia, Md 20a. METHOD OF DISPOSITION

MXBurial 2 □ Cremation 3 □ Removal from State 26c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE "Meadowridge Memorial 4 Donation 5 Other (Specify) Pk 6/6 Elkridge, Md 21. BIGHTURE OF FUNERAL SERVICE LICENSEE. 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata ahock, or heart failure./List only one cause on each line. DOXEPIN & ALCOHOL INTOXICATION COMPLICATED BY IMMEDIATE CAUSE (Final Onset and Death disease or condition\_ PULMONARY THROMBOEMBOLISM reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 | NO OF DEATN? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER: XXYES 2 NO 1 Inpetiant 2 □ ER/Outpetient 3 □ DOA Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Netural 5/31/95 10:00 P M 1 YES 2 XXNO SUBJECT INGESTED DRUGS 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 5495 CEDAR LANE APT.707 COLUMBIA, MD. 21044 3 🗌 Suicide 8 Could not be 4 Homicide RESIDENCE COLUMBIA, MD. 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, dats and place, and dus to the cause(s) and menner as stated. 25 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated,

29c. LICENSE NUMBER

O.C.M.E.

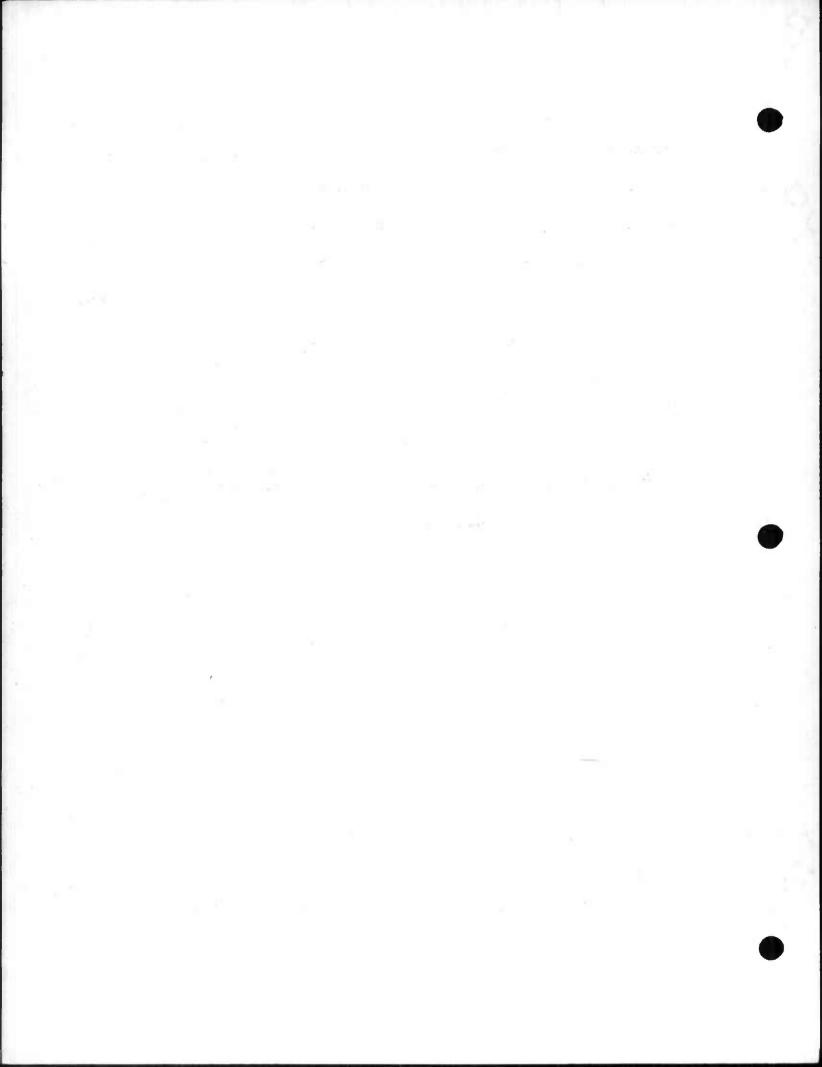
111 Penn Street, Baltimore, Maryland 21201

hours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE HOSPITS
TO THE FUNERA
De filed within 7
IMPORTANT: I

**DHMH-18 Ray 1/89** 

29d. DATE SIGNED (Month, Day, Year)

▶ JUNE 01,1995



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CERTIFICATION

MEDICAL

PHYSICIAN:

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95 18624 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY 25,1995 RUTH PERROTT 11:00 P LEWIS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 - M 2XX 216-46-8264 YRS. 94 SEPT. 29,1900 VIRGINIA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 8905 GRANT STREET BETHESDA MONT. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD MONT. **BETHESDA** 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 8905 GRANT STREET 20817 S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2X NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married 3 Widowed 4 Divorced Specify. WHITE 16e. DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER HEALTH SERVICES 17. FATHER'S NAME (First, Middle, Last) te. MOTHER'S NAME (First, Middle, Maiden Surname) ELMER LEWIS HATTIE UNKNOWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21203 ANNE OVIZ AYRES TWO HOPKINS PLAZA, P.O. BOX. 2257 BALTIMORE, MD. 20e. METHOD OF DISPOSITION
1 □ Burial 2X□ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State MT. COMFORT CREMATORY 4 Donation 5 Other (Specify) 6/3 ALEXANDRIA, VA. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOS. GAWLERS SONS INC. 5130 WI AVE NW WASHINGTON, D.C. 20016 mon 23. PART I. Exter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Betw **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition\_ KESPIRATORY resulting in death) DUE TO (OR AS A CONSEQUENCE OF): STAGE Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 N Residence 8 Other (Specify) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural

28a. DATE OF INJURY (Month, Day, Year)

28c. INJURY AT 1 YES 2 NO 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)

#227 SILVER SPRING, MARYLAND 20902

29a. CERTIFIER (Check aniv 1 K) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

RE AND TITLE OF CERTIFIER	·M44 M140	29c.

LICENSE NUMBER um vermy mu

29d. DATE SIGNED (Month, Day, Year) MAY 26,1995

281, LOCATION (Street and Number or Rural Route Number, City or Town, State)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MERLYN K. VEMURY M.D. 9801 GEORGIA AVE

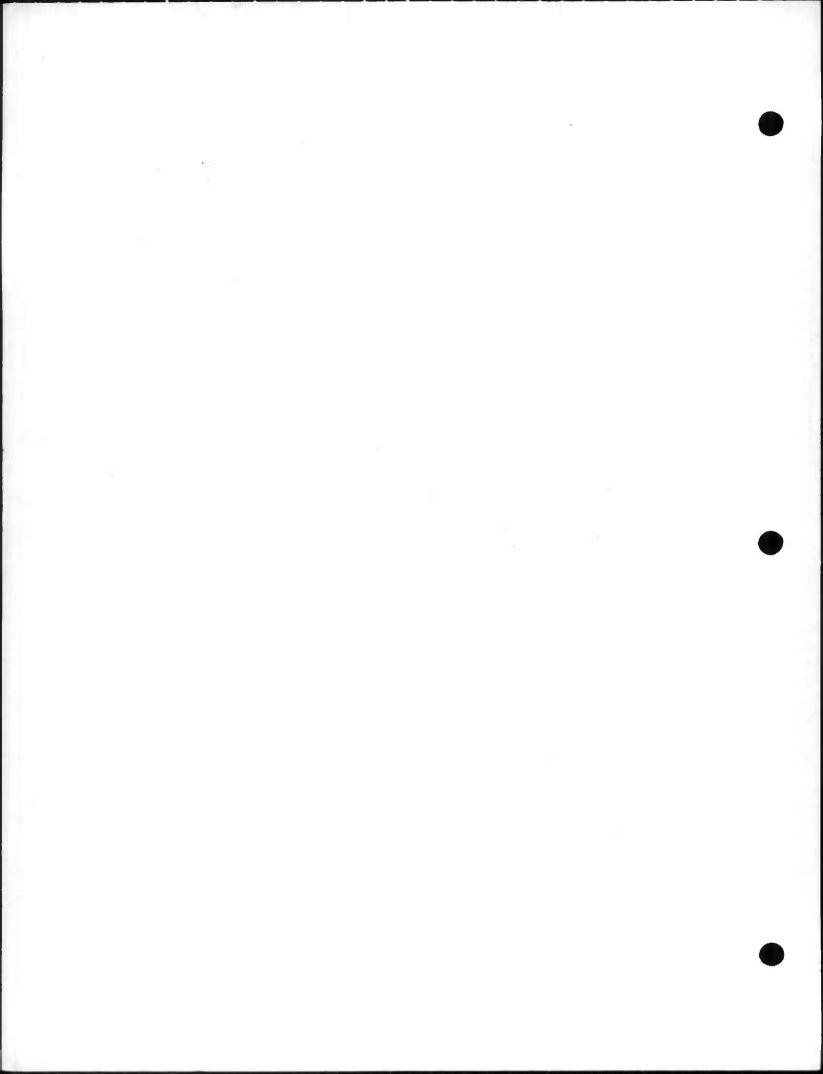
5 Pending

6 Could not be

determined

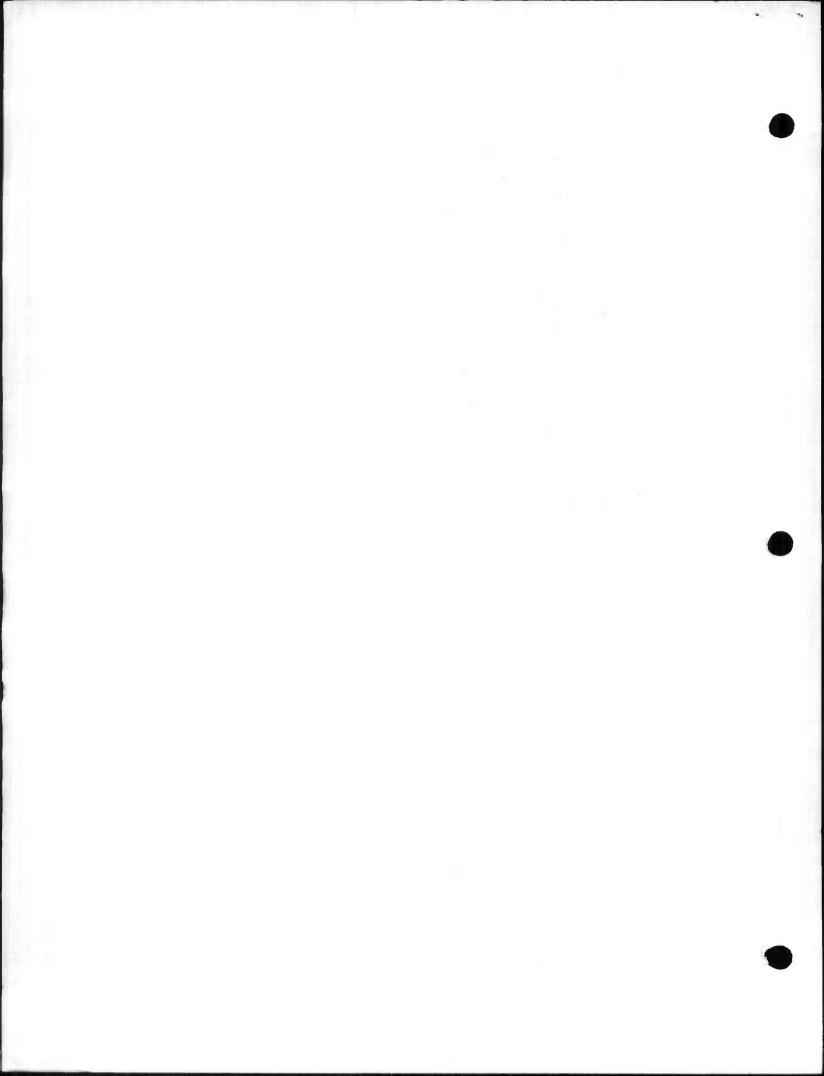
32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) MAY 1995

Davden Ron



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within control after death. Page 6 may be retained by the hospital or attending physician.  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within control after death. Page 5 mount of the physician or attending physician and completely filled in by the function, page 5 should be detached for use as the bunish-transit permit. Pages 1, 2, 3 should be detached for use as the bunish-transit permit. Pages 1, 2, 3 should be detached for use as the bunish-transit permit.	De Ried Within 72 Hours after Death With the State Dept. United that mental supporte process of the months of the
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	FOR 1 - STATE REGISTRAR	STATE OF N		DEPAR						YGIENE				
	1. DECEDENT'S NAME (First, Middle, L.	nst)							2. DATE OF I				3. TIME OF DEATN	
1 1	Marcella Wils	on Pfeiffe	r						May	2	ž 1	995	2:00	) au
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	st birthday)	IF UNDER		IF UNDER		7. DATE OF E	BIRTN		8. BIRTN Country	PLACE (State or Fore	ign
1	220-24-0325	1 🗆 M 2 💢 F	66	YRS.	MONTHS	DAYS	HOURE	MIN.	June	5 :	1928	Ne	w York	
	9a. FACILITY NAME (If not institution, g	ive street and number)			9b. CITY	TOWN C	R LOCATIO	ON OF DE	ATN		9c. COU	NTY OF O	EATH	
18	8483 Hill Str	reet			l I	Ellic	cott	City	У		F	Iowar	cd	
5	RESIDENCE OF DECEDENT												10d. INSIDE CITY	
DIRECTOR	Margal and				TY, TOWN								LIMITS?	
1 1	10a. STREET AND NUMBER	1									1 YES 2X P	10		
MA	106. STREET AND NUMBER 107. ZIP COOE 108. A. U.S.A.													
FUNERAL														
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3X Widowed 4 Divorced	YES 2 X							Black	14. RACE — American Indien, Black, White, atc. Specify: White				
8	15. OECEOENT'S	EDUCATION	16a. C	ECEDENT'S Give kind of	USUAL O	CCUPATIO	ON of world		16b. KIN	D OF BUS	INESS/IN	DUSTRY		
	(Specify only highest g Elementary/Secondary (0-12)	College (1-4 or 5		e. Do NOT u	ise retired.)	aunny mo	St Of WORK	ny .						
Ē.	12			Wea	aver				S	elf I	Emplo	oyed		
COMPL	17. FATNER'S NAME (First, Middle, Last								ME (First, Midd		Surneme)			
ш	James A. Jone	S					He	elen	Vecch	io				
TO B	19a. INFORMANT'S NAME (Type/Print)		1						Route Number, (				7 0704	,
	Michele C. Dru	ry				_			licott				and 21043	3
	20a METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3	Removal from State	20b. PLACI	E OF DISPO			metery, crer	matory or			cation —			
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE	F I IOENDEE	-	VVC	200		IO ADDRE	00 OF 54	OII (TV				PIU.	
1 3	21, SIGNAL ONE OF PUNERAL SERVICE	A A			F	IARR	Y H.	WIT	ZKE FU	NERAI	L HOV	Œ		
	Them 6	1. Colle	~~		4.	112	old (	Colu	mbia P	ike,	Ellic	cott	City 210	)43
TION	ahock, Dr heart failure. Liet Dnly one ceuse Dn aech line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Sequentielly list conditions, if eny, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  C. DUE TO (OR AS A CONSEQUENCE OF):													
	PART II. Other algoliticant cond	litiona contributing to	death but not	resulting	In the u	nderivin	a cause	alven in	Part I. 24	a. WAS AN	AUTOPSY	248	. WERE AUTOPSY FI	NDINGS
PHYSICIAN: MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 MO  24b. WERE AUTOPSY FINDINGS AMALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO										AUSE			
YSICIAN	25. WAS CASE REFERRED TO MEDIC	AL:				26. P	LACE OF I	DEATH (C	heck only one)					
Sic	EXAMINER?	HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHE		no 5 (44)	lesidence	6 Other (S	ipec/fv)				
BY PHY	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF 28c. INJURY AT WORK?  1 Netural 5 Pending  M 1 Yes 2 PNO													
	2 Accident trivestigation 3 Suicide 8 Could not be 4 Homicide determined  28e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
D BE COMPLETED	29a. CERTIFIER (Check only one)  2   MEDICAL EXAMINER: On the basis of examination and the time, data and place, and due to the cause(a) and manner as stated.													
3	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)													
BE		20				246		<b>•</b>	D.30.85					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
	Charles E. Sheehan, III, M.D., 10298-B Balto. Natl. Pike, Ellicott City, MD 21042													
	31. DATE FILED (Month, Day, Year) MAY 3 0 19	32. REGISTR	AR'S SIGNATURE											
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH
7. DATE OF BIRTH Angela 1995 owichroski 0725 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreig Oct 1, 1926 DAYS 217-22-3876 1 M 2 F 68 Maryland permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR St. Agnes Hospital Baltimore Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Howard Ellicott City 1 YES 2XXNO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8813 Autumn Hill Court funeral director, page 5 should be detached for use as the burial-transit 21043 United States retained by the hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnam notified at BE Raffaelle Grecco Rose LaVerghetta 18a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8813 Autumn Hill Court Ellicott City, MD 21043 Powichroski hours after death. Page 6 may be must be 20s, METHOO OF DISPOSITION
1 & Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 29c. LOCATION — City or Town, State St. John's Cemetery 4 Donation 5 Other (Specify) June 2 Ellicott City, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc coll Then 4112 Old Columbia Pike Ellicott City 21043 and completely filled in by the oburial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert failure. List only one cause on each line. 0 Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disesse or condition\_\_\_ Cancer retastaces Breast event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate attending physician the death certificate be cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 been signed by the atte PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY PERFORMED? shows any i 1 TYES 2 X NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) this certificate It HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28s. PLACE OF INJURY — All home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 89 ETED. 8 Could not be 4 Nomicide 28 determined Hem 29a. CERTIFIER 1 🗵 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as attated. COMPL TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Yump Roshal , Medical Resident May - 30 - 95 D022323864 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) st AGnes Hospital, 900 caton, Baltimore, MD 21229 RAHAL

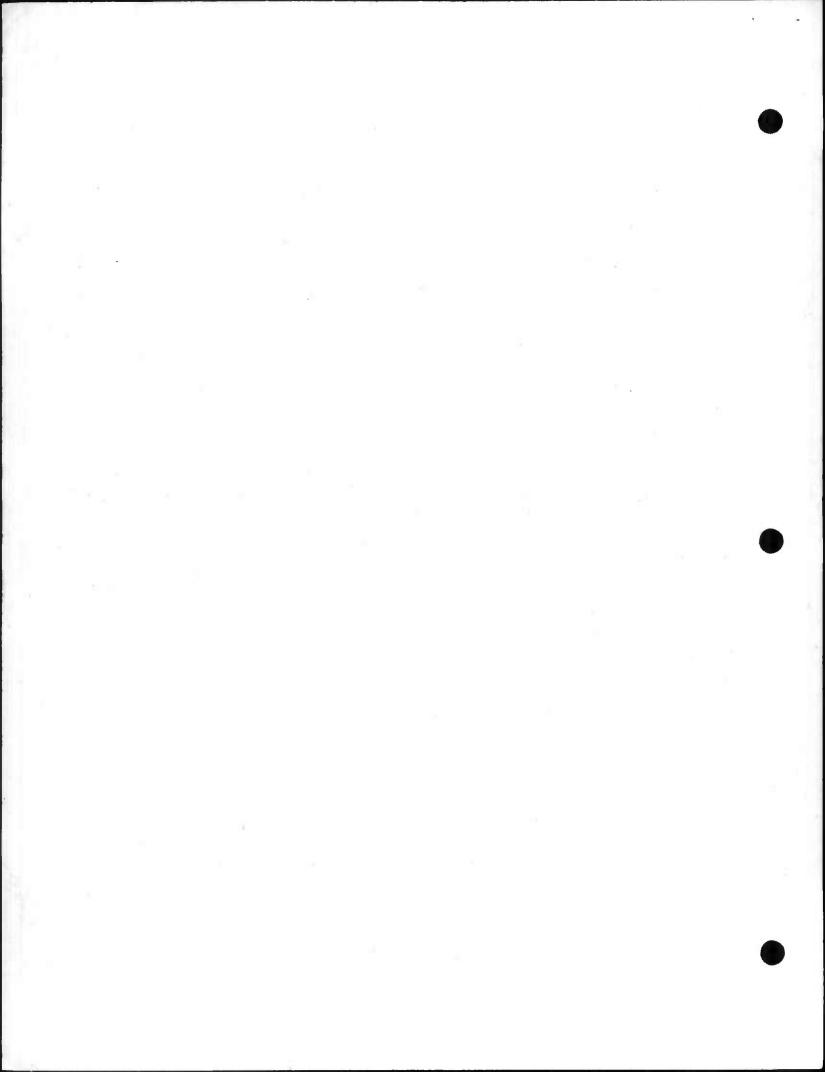


31. DATE FILEO (Month, Day, Year)

JUN 01

1995

32. REGISTRAR'S SIGNATURE Julia Davidson Randall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or afterding physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - FOR STATE REGISTRAR	STATE OF MAR		RTMENT OF I		MENTAL HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last) MICHAEL	D.	PANGBUR			2. DATE OF DEATH DATE OF THE D	YEA	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER  218-96-1680  9a. FACILITY NAME (If not institution, give a	1 🔀 M 2 🗌 F	GE (In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 03-26-19	Co	RTNPLACE (State or Foreign unitry)  MD		
TOR	98. FACILITY NAME (If not institution, give street and number)  SUSQUEHANNA RIVER(NORTH PARK)  BESIDENCE OF DECEMENT  96. COUNTY OF DEATH HAVRE DE GRACE  HARFORD									
DIRECTOR	MD I	MD Harford				Havre de Grace				
FUNERAL	837 Erie Stre				101. ZIP CODE 10g. CITIZEN OF WHAT US					
BY	11. MARITAL STATUS  1 X Never Merried 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 YES 2 NO Specify:  Wh					
COMPLETED	College (1-4 of 8+)				usual occupation work done during most of working se retired.)  Ident  Middle School					
BE COM	17. FATHER'S NAME (First, Middle, Lest)  Jeffery Wad	e Pangburr		udent	11/0-12/12/19/19	ME (First, Middle, Meiden nna Delynr	Surname)			
TO B	196. INFORMANT'S NAME (Type/Print)  M/M Jeffery W. Pangburn  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  837 Erie Street, Havre de Grace, MD 2107									
	20e. METNOD OF DISPOSITION 1 IN Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ery	6/7 Ha	vre de	Grace, MD		
	► Lideloin	2 8	AL	Mitch Havr	e de Gra	h Funeral ace, MD	21078-3	P.A. 3197		
	23. PART I. Enter the diseases, or a shock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Liet Drily Drie cause Di	n each line.		de of dying, suc	h as cardisc or reapi	retory arreat,	Approximate Interval Batween Onset and Death		
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR A	AS A CONSEQUENCE O							
PHYSICIAN: MEDICAL CERT	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  24b. WERE AUTO OF DEATHY  1 YES 2 NO  1 YES 2 NO  1 YES									
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one)				AMAIN DYNED		
ву Рну	27. MANNER OF DEATN  1 Netural 5 Pending 2 Accident trivestigation	1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Nome 5   Residence   8   Other (Specify) SIISOIIFHANNA								

					EO E NO
DID TOBAC	CO USE CONT	TE TO CAUSE OF DEATH YES T	NO UNCERTAI	N 🗆	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check	only one)		
		SPITAL: OTHER Inpetient 2 ER/Outpetient 3 DOA 4 Num		8 G-Other (Specify) SUSOUEHANNA	PTVFI
27. MANNER OF DE  1 . Natural  2 . Accident	ATN 5 Pending Investigation	28e. DATE OF INJURY 5 (Month. Pey, Year) COO PM	28c. INJURY AT WORK?  1 YES 2 NO	SUBJECT PROWNED	T. V.
3 Sulcide 4 Nomicide	8 Could not be determined	28a. PLACE OF INJURY — At home, farm, street, fact building, stc. (Spec/ly)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State) SUSGUE HANNA PUER HAR FOR		

29a. CERTIFIER (Check only one) CERTIFYINO PNYSICIAN: To the best of my knowledge,

ath occured at the time, data and place, and due to the cause(s) and manner as atated.

29c. LICENSE NUMBER JUNE 04, 1995 O.C.M.E.

111 Pen

Montrages signatures

Manufactures Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Mor

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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31. DATE FILED (Month, Day, Year)
JUN 1 4 1995

	ITEMS: 23 PA	RT I, 27, 28	Ba-f, PER MEO	FILM G-7	25 7/5/95 t	:.t	50	1.0	3628
	1 - STATE REGISTRAR	STATE OF MA	ARYLAND / DEPA		HEALTH AND	MENTAL HYGII			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF DEATH
	KENNETH  4. SOCIAL SECURITY NUMBER	ALLAI	100		ERRY	JUNE	6		:00 Pu
	217-96-8928	1 M 2 F	. AGE (In yrs. last birthday) 29 YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year,		Country)	ACE (State or Foreign
_	9a. FACILITY NAME (If not institution, give st	treet and number)		9b. CITY, TOW	N OR LOCATION OF I			Wasiii NTY OF DEAT	ngton DC
DIRECTOR	1300 blk.RAILR	OAD AVE		BC	WIE	PRI	INCE	GEORGES	
EC C	10a. STATE 10b. COUNTY	r	10c, Cf	TY, TOWN OR LO	CATION			100	d. INSIDE CITY
		ce George'	S	Clinton	1			1 [	LIMITS?
RAL	100. STREET AND NUMBER	av Road			101. ZIP CODE 20735		10g. CITI	ZEN OF WHA	
FUNERAL	12909 Piscataway Road 20735 U.S.  11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No) 14. BACE.								
BY FI							Black, W Specify:	hite, atc.	
	3 Wildowed 4 Divorced	2471011						Caucas	ian
ETED	(Specify only highest grade  Elementary/Secondary (0-12)	completed)	(Give kind of life, Do NOT a	work done during	TION most of working	16b, KIND OF	BUSINESS/IND	USTRY	
MPL	12th	N/A	Senior	Work Co	ntrol Cle	erk Andrew	s Air	Force	Base
17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Robert Earl Perry Mary Dolores Grimes  19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Roune Number, City or Town, State, Zip Code)							S		
2	Robert Earl Peri	ry				. Clinton,			
	20s METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Remo	oval from State	20b. PLACE AND DATE	OF DISPOSITION			LOCATION —		State
	4 Donation 5 Other (Specify)		Resurrect	ion Com	otory	1005	lintor	. Mar	vland
	21. SIGNATURE OF FUNERAL SUPPLICE LIC	STREET, STREET		22. NAME	AND ADDRESS OF F	Lee Fu	neral	Home,	Inc.
	MATE I	WHAT.							
	23 PART I Enter the diseases or o	amplications that a	and the same			xandria Fe	-		
	23. PART I. Enter the diseases, or c ahock, or heart failure. I	complications that c	aused the death. Do on each line.				-		Approximata Interval Between
	ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition	List only one cause	aused the death. Do on each line.				-		Approximata
	ahock, or heart fallure. I IMMEDIATE CAUSE (Final	MULTIPLE	on each line.	not enter the I			-		Approximata Interval Between
NO	ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions,	a. MULTIPLE DUE TO (OF	INJURIES	not enter the r			-		Approximata Interval Between
CALION	ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. MULTIPLE DUE TO (OF	on each line.	not enter the r			-		Approximata Interval Between
IIFICATION	ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	BUE TO (DE	INJURIES	not enter the r			-		Approximata Interval Between
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5	ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	B. MULTIPLE DUE TO (OF	ON BOOK THE S  R AS A CONSEDUENCE OF AS A CONSEDUENCE OF AS A CONSEDUENCE OF AS A CONSEQUENCE OF AS A CONS	not enter the p  OF):  OF):	noda of dying, su	n Part I. 24s. WAS	AN AUTOPSY	eat,	Approximata Interval Between Onset and Death  RE AUTOPSY FINDINGS
5	ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST	B. MULTIPLE DUE TO (OF	ON BOOK THE S  R AS A CONSEDUENCE OF AS A CONSEDUENCE OF AS A CONSEDUENCE OF AS A CONSEQUENCE OF AS A CONS	not enter the p  OF):  OF):	noda of dying, su	n Part I. 24s. WAS	pintory arr	24b. WE	Approximata Interval Between Onset and Death
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DI PRISICIAN: MEDICAL CE	ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in dasth)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. Other significant conditions  DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	BULTIPLE DUE TO (OF DU	ON EACH TIME  INJURIES  R AS A CONSEDUENCE OF RAS A	DF):  DF):  In the underly  ES NO  NTH (Check only or  OTMER: 4 Nursing H  AE OF  26c. JURY 1 1	Ing cause given in UNCERTAL  DOTE: 5 □ Residence  NURY AT  NORK?  YES \$\( \) ND	n Part I. 24a. WAS. PERF 1 YES IN C 24d. DESCRIBE HON SUBJECT RU	AN AUTOPSY ORMED? 2 NO  AT SC	24b. WE AM COO OF 1 CENE	Approximata Interval Between Onset and Death Onset and Death RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
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OMPLETED BY PHISICIAN: MEDICAL CE	ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST  PART II. Other significant conditions  DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	BUE TO (OF DUE TO (OF	ON EACH TIME  R AS A CONSEDUENCE OF R AS A C	DF):  DF):  In the underly  ES  NO  NTH (Check only or  OTHER: 4 Nursing H  E OF 26c. JURY 5 P M 1  street, factory, of  AD TRACKS  red at the time, di	Ing cause given in UNCERTAL  UNCERTAL  Dome 5 Residence NJURY AT  WORK?  YES 200 ND  fice	IN D  6 X Other (Specify)  28d. DESCRIBE HON SUBJECT RUI 28f. LOCATION (Stre City or Yown, Sta BOWIE, MD.	AT SC VINJURY OCC (OVER B) on Mumber (19) 300 B)	24b. WEI AM COO OF 1 CENE BY IRAI POLICE RAI RAI	RE AUTOPSY FINDINGS INLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
LETED OF PRINCIAN. MEDICAL CE	ahock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST  PART II. Other significant conditions  DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be detarmined  29a. CERTIFIER 1 CERTIFING PHYSIC	BULTIPLE DUE TO (OF  DUE TO (O	ON EACH TIME  R AS A CONSEDUENCE OF R AS A C	DF):  DF):  In the underly  ES  NO  NTH (Check only or  OTHER: 4 Nursing H  E OF 26c. JURY 5 P M 1  street, factory, of  AD TRACKS  red at the time, di	Ing cause given in UNCERTAL  UNCERTAL  Dome 5 Residence NJURY AT  WORK?  YES 200 ND  fice	IN Depart I. 24a. WAS. PERF 1 YES IN DESCRIBE HON SUBJECT RUN (Street, City or Yown, State BOWIE, MON at the cause(a) and no time, data and piace, UMBER	AT SC INJURY OCC I OVER BY and Number (e) 1300 Bill beanner as atate and due to the	24b. WE AM COY OF 1 CENE UNED 3Y IRAI! or Rurel Route LK. RAI	RE AUTOPSY FINDINGS INLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO

DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

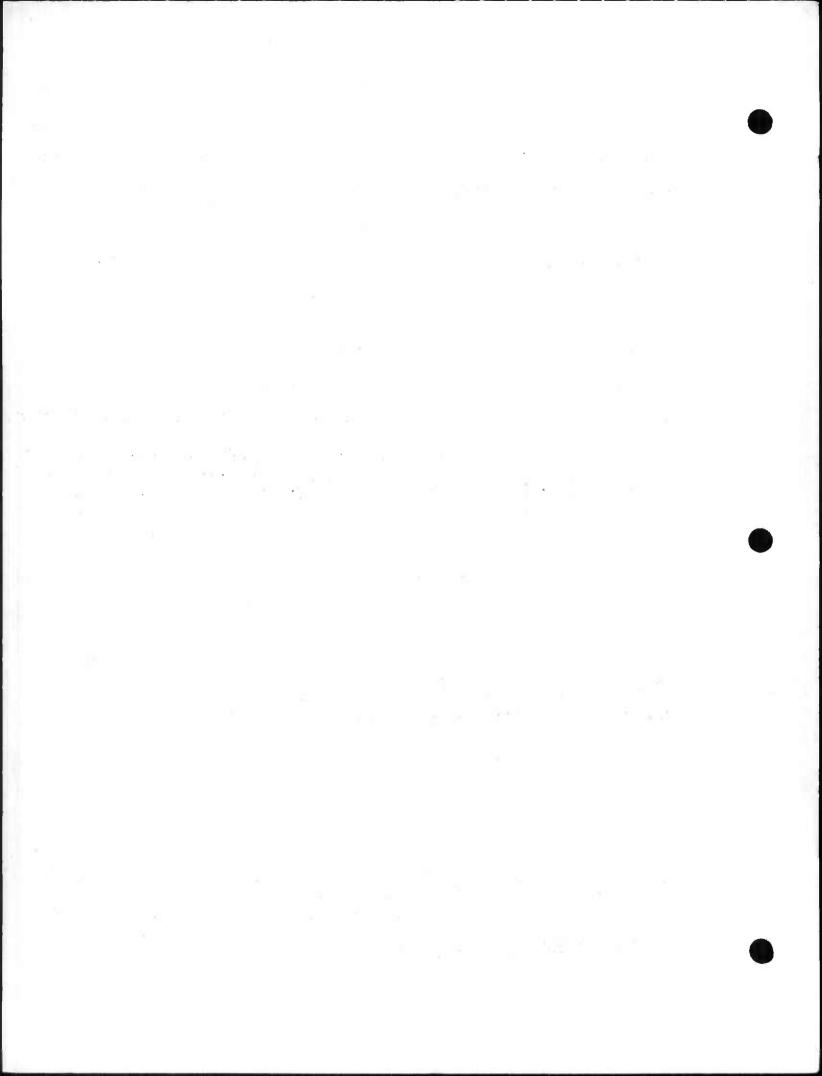
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with norms after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: It liem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 2	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATN														
- 4	Jack Stewar	t Payne							MONTH	2 DAY	9	YEAR 95	11	7 ! K	0
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF 8	URTH		a. BIRTN	PLACE	(State or F	omion
	213-01-1048	1 XM 2 - F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	June	6,19	918	Nor	th	Car	olin
	Sa. FACILITY NAME (If not institution, giv	e street and number)							NTY OF D						
H H	Frederick Me	morial H	ospita	1	Fı	red	eric	:k				ede		:k	
DIRECTOR	RESIDENCE OF DECEDENT														_
뿐	10e. STATE 10b. COU			10c. CITY, TOWN OR LOCATION Frederick									ISIDE CIT	, i	
	4	ederick		Fr	edei	ric	K						1 TES 2 1 NO		NO
¥.	10e. STREET AND NUMBER			101. ZIP CODE					10g. CIT		EN OF WHAT COUNTRY?				
崱	2404 Dominio	n Drive	- 1-C	21702			τ			U.S	. A .				
FUNERAL	11. MARITAL STATUS  1 ☐ Never Married 2 ★ Married		T EVER IN U.S. AF				IC ORIGIN? (S	pecify Yes	or No—	14. RACE Black	- Ame	erican Indi	an,		
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR OATES							Specify		,,		Speci	"W	ite	
ED 8	15. DECEDENT'S E	DUCATION	100 00	CEDENTIA	1				1				101	1100	
	(Specify only highest gra	de completed)	(G	CEDENT'S live kind of a Do NOT us	vork done o	during mo	on st of working	ng	16b. KIN	O OF BUSI	NESS/INI	DUSTRY			
2	Elementery/Secondary (0-12)	College (1-4 or 5	+)		air				T	elev	/isi	on			
COMPLET	17. FATHER'S NAME (First, Middle, Last)						40 1407	UEDIO NA	ME (First, Middle	Maldan					
	Luther Payn	Α.						orq		ook	umame)				
H	19a, INFORMANT'S NAME (Type/Print)		1 +0	h MAILING	ADDRESS	(Stenal o			loute Number, C		State 2/	- 0-4-1			
2	Ruth Gue Payn	e							1-C,		,,		. N	ſđ.	2170
- 0	20e. METHOD OF DISPOSITION		20b. PLACE						DATE			City or To			2114
	Donation 5 Other (Specify)	movel from State	cemetery, cre	emetory or or	ther place!				1						
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Moun	t Ta				SS OF FAC	6/1	Etc	chis	son,	Ma	ryl	and
	ml. of	600	4/						eswor	th, F	P.A.	, Fu	ner	a1	Home
	Clan L.	desu	1am						Road				, Ma	ry1	and
	23. PART I. Enter the diseases, or ahock, or heart fellur	r complications the	t caused the de	eeth. Do r	ot enter	the mo	de of dy	ing, such	as cerdiec	or respire	etory sr	rest,		pproxim	
	IMMEDIATE CAUSE (Final Onsat and Death														
	disease or condition resulting in death) s. Strake									re					
	,	OUE TO	(OR AS A CONSE					-	/				1	_//1	• >
Z	Sequentisticy list conditions, b. A cute upper GI bleeding I week									rack-					
Ĕ	if any, leading to immediate	DUE TO	(OR AS A CONSE	OUE ICE OF	7:										
CERTIFICATION	CAUSE (Disease or injury	c.											-		
E	that initiated eventa reaulting in desth) LAST	DOE 10	(OR AS A CONSE	QUENCE OF	ን:										
H		d											-		
	PART II. Other significent conditi	ons contributing to	deeth but not i	resulting i	n the un	deriying	ceuse (	given in	Part I. 24a	. WAS AN A		24b.		UTOPSY F	
EDICAL	Dilated	Cardion	nyong	Thu	The			PERFORMED?				AVAILABLE PRIOR TO COMPLETION OF CAUSE			
	Chronic o	bstruc	1 1 11	11	rong	en	di	can		1159 2	NO		OF DEA		
2	DID TOBACCO USE						ES I		-				1 📙 1	ES 2 🗌	NO
A	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTI	L TO CAU	JE OF	DEAT			NO EATN (Che	ick only one)					_	-
PHYSICIAN:	EXAMINER?	HOSPITAT:	ER/Outpetlent 3	I DOA	OTHER	1:									
Ŧ	27. MANNER OF DEATH	28a. DATE OF		28b. TIM		28c. JNJ		sioenca	6 Other (Sp.		ILIBY OC	CURED			-
	t Natural 5 Pending	(Month, E	lay, Year)		URY	wo	RK?	ON C		2 11011 111		OUNED			
B	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE C	F INJURY — At ho	ma, farm, s	treet, tacto			J	28f. LOCATIO	N (Street en	d Numbe	or Burnt B	housto Nu	mher	
	4 Homicide B Could not be determined	• building,	etc. (Specify)			,,	-	- 1	City or To		TO THOM	or vioral r	ODIO NO	moon,	
COMPLETENBY	29a. CERTIFIER	(0)(0)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)													
A P		SICIAN: To the best of													
8		NER: On the beele of e	xamination anglor	investigatio	n, in my o	pinion, d	eath occur	ed at the	time, date end	placa, and	due to ti	he ceuse(s	) and m	anner aa s	tated.
H	296. SIGNATURE AND TITLE OF CONTIF	IER /		11	_		29c. LICI	ENSE NUM	BER	2-3	29d. DAT	E SIGNED	(Month,	Day, Year)	/-
2	Idea of	· Cope	Tola	to	M	<b>′</b>	1	13	5/8	5		5	12	91	75
	30. NAME AND ADDRESS OF PERSON	VHO COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type,	Print)		at	7	21	/	7	1		1	
	HIIJIH	FOOK	16h	50	v c	U	7"	7	Stre	et	Tre	der	161	1	MD
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	division l	0	1										
	MAY 3 1 19	35 Jun	ammine	wood	<b>(</b> 1)										



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STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

296. BIGHATURE AND TITLE OF CHE

Tonathan

JUN 05 1995

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lice (1) June 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 94 HOURS 10-8598 1 🗌 M 2 🗸 F YRS. January 21 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Northurst Hos DIRECTOR HospitAl Kandallstown 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Baltimore Keisterstown Md. permit. FUNERAL 10e. STREET AND NUMBER tof, ZIP CODE 1140 Road Deel the burial-transit Park 21136 or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cutten, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced use as t ED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sp ᆸ for Elementary/Secondary (0-12) College (1-4 or 5+) hospital COMPL 5 detached seamstress shirt factory once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) 24 hours after death. Page 6 may be retained by the 7 Albert funeral director, page 5 should be Purcel1 В. Carrie BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lee Smith 6140 Deer Park Rd., Reisterstown, MD 21136 9 20a. METHOD OF DISPOSITION

1X Ruriel 2 ☐ Cremetion 3 ☐ Rett 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must el Irom State Parsons Cemetery

Parsons Cemetery 4 Donation 5 Other (Specify) 6/5 the medical examiner 21. SIGHATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801 completely filled in by the 23. PART I. Enter the diseases, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause of each line. IMMEDIATE CAUSE (Finel disesse or condition resulting in death) Phlumonia event. DUE TO (OR AS A CONSEQUENCE OF): executed bunal, traumatic CERTIFICATION and Sequentially liet conditione, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate the attending physician Mental Hygiene prior tr that the death certificate be cause. Enter UNDERLYING CAUSE (Diseese or Injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY een signed by the ongestive Herrt FRILLIPE shows any 1 YES 2 NO has been s Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The tem this certificate h State HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Realdence 8 □ Other (Specify) 1 YES 2 NO 1 Inpetient 2 ER/Oulpetient 3 DOA the of 27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, t Natural 5 Pending 1 YES 2 NO BY L DIRECTOR: After to hours after death 2 Accident Investigation 28a. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28 is 8 Could not be COMPLETED 4 🗌 Homicide datermined Item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the cause(e) and manner as stated. THE HOSPITAL O THE FUNERAL D filed within 72 hc TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If Ite 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner ea stated.

MD

Nushner

32. PEGIŞTRAP'S SIGNATURED

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

95 18630

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

white

t YES 2 NO

**Approximate** Interval Between

24b. WERE AUTOPSY FINDINGS

AWAIL ARLE PRIOR TO

1 YES 2 NO

29d, DATE SIGNED (Month, Day, Year)

COMPLETION OF CAUSE

Onset and Death

days

8. BIRTHPLACE (State or Foreign

maryland

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

USA

Hastings

Salisbury, MD

7/5

REG. NO

2. DATE OF DEATH

29c. LICENSE NUMBER

114 Business Center Dave

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memail Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED (Month, Day, Year)

	Item 23 Part I	,27,Per M	EO,P.G.	,GC,	6/8	3/95				9	5	8631
	1 - STATE REGISTRAR	STATE OF N	MARYLAND C	DEPAR	TMEN	T OF H	EALTH DEAT	AND N	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			. TIME OF DEATH
3	Josephine		Perkins					MONTH	DAY	YEAR		
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. Id		,	ER 1 YEAR	AR IF UNDER 24 HRS. 7, DATE OF BIRTH			10	95	0910 "
		1 M 2 TYF		YRS.	MONTHS	1	HOURS	MIN.	(Month, Day, Year)		B. BIRTHPI Country)	LACE (State or Foreign
	_578-76-0756		11 30						3-26-57		Kers	shaw, SC
-	9a. FACILITY NAME (If not inatitution, give s	treet and number)			9b. CIT	TY, TOWN	R LOCATIO	N OF DE	ATH	9c. COL	JNTY OF DEA	
OH	Prince Georges	Hospit	al Cen	ter	Cheverly						0	
DIRECTOR	RESIDENCE OF DECEDENT			_						IPT	nce	Georges
R	100.00011			10c. CIT	Y, TOWN	OR LOCAT	ION					0d. INSIDE CITY
	MD. Prine	ce George	S	I	Bren	twoo	đ				1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE			10a, CI		AT COUNTRY?
E.	3300- 42nd Ave	າມອ					2072	2			U.S.A.	
Ž	11. MARITAL STATUS	12. WAS DECEDEN	T EVED IN II C A	BMED	1 40							
딥	1 Never Married 2 Married	FORCES7 1	YES 2 X	NO	13	If yes, sp	ecify_Cuben	, Maxicar	IC ORIGIN? (Specify Y n, Puerto Rican, etc.)	es or No-	14. RACE - Black,	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			1 TYES	2 NO	Specify			Specify:	
	15. DECEDENT'S EDU	CATION									Bla	ack
COMPLETED	(Specify only highest grade	completed)	18a. D	ECEDENT'S Give kind of	Work done	OCCUPATION OF THE PROPERTY OF	ON si of worlding	7	16b. KIND OF B	USINESS/IN	DUSTRY	
۳ ا	Elementary/Secondary (0-12)	College (1-4 or 5 +	)						ľ			
MP		2		Bank	Tel	ler						
Ö.	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM	ME (First, Middle, Maide	n Sumame)		
BE (	George A. I	Perkins					D	aisy	Segears			
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	SS (Street a	od Number r	or Burnt B	loute Number, City or To	un Chain 7	in Carles	
2	Pose M Porking-W	ina										
ROSE FI. PERKINS-KING /100- Riggs Rd., Hyattsville, MD. 2  20a. METHOD OF DISPOSITION 1 A Burlei 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of State Constitution of Constitution Con												
								-				
	4 Donation 5 Other (Specify)		Fort	Line					5/16 Br	centw	ood, M	D.
1	21, SIGNATURE OF FUNERAL SERVICE LIC	/	/		22	HAME AN	D ADDRESS	S OF FAC	neral Char	. for	Tna	
	► 16 1 X	W. Hac	LITT								Inc.	
$\dashv$	19 Stiff   Enter the diseases or completeless that extend the death Post of the Complete Comp											
	shock, or heart fellure. List only one cause on each line.  Approximata Interval Between											
	IMMEDIATE CAUSE (Final											Onset and Death
	disease or condition resulting in death)	DISSE	CTION O	F COF	RONA	RY AI	RTERY					
		DUE TO	OR AS A CONSE	QUENCE OF	F):							
z												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	DUE TO	OR AS A CONSE	OUENCE OF	F):							
¥	cause. Enter UNDERLYING											j. I
H	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSE	OUENCE OF	F):							-
E	resulting in death) LAST				,							į i
9		f										
	PART II. Other significent condition	s contributing to	death but not	resulting i	In the u	nderlylns	cause al	ven in F	Part I. 24a. WAS A	N AUTOPSY	24b W	ERE AUTOPSY FINDINGS
5									PERFO	RMED?	A	WAILABLE PRIOR TO
<u></u>									1 TES	2 🗌 NO		OMPLETION OF CAUSE F DEATH?
ž									_		1,	YES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAL	USE OF DEA	ATH YE	S 🗆	NO Z	UNCE	RTAIN				
<u></u>	25. WAS CASE REFERRED TO MEDICAL		26. PLA	CE OF DEAT	TH (Check	only one)						
8	EXAMINER?  1 DXYES 2 NO	HOSPITAL:	ER/Outnatiant	1 DOA	OTHE			latina d	3 Other (Specify)			-
<b>≟</b> I	27. MANNER OF DEATH	28e. DATE OF		26b. TIM		28c. INJI		idence (	28d. DESCRIBE HOW	IN HIEW OC		
	Natural 5 Pending	(Month, De		INJ	URY	WO	RK?		200. DESCRIBE NOW	INJUNT OC	COMED	
B	2 Accident Investigation						ES 2	NU				
	3 Suicide 8 Could not be 4 Homicide determined	building, e	FINJURY — At ho Hc. (Specify)	ome, ferm, s	itreet, fac	ctory, office	•		281. LOCATION (Street City or Town, State		r or Rural Rou	te Number,
E	roundoe getermined											
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of i	my knowledge, de	eath occurre	d at the	time, data	and place 4	and thus	to the cause(a) and ma	mper ee et-	ted	
Z	one) 2 X MEDICAL EXAMINE											nd manner ac stated
8					, ,	,,			, one and prece, a	I UI DUU II	re cense(a) a	THE THEORY OF STREET,
H	296. SIGNATURE AND TITLE OF CERTIFIER	1 10					29c, LICEN	ISE NUMI	BER	29d. DAT	E SIGNED (M	lonth, Day, Year)
0	Neum	7 7 7 7	ans				0.	C.M	.E.	Ma	ay 11	1995
	30 NAME AND ADDRESS OF DERSON WIN	/									_	

PERSON WIN COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

111

Penn Street, Baltimore, Maryland

•

ITEMS: 23 PART I, II, 27, PER NEO FILM G-725 7/5/95 t.t

95 18632

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH WINFRED MAY 1995 PEAY JR. 26, 0955 AM 4 SOCIAL SECURITY NUMBER 5. SEX 8, AGE (In vrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR A. BIRTHPLACE (State or For IF UNDER 24 HRS. 578-68-3090 November 20, Washington, D.C. 1 X M 2 - F 1949 45 YRS Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Pages 1, 2, 3 DIRECTOR PATUXENT RIVER HOSPITAL E.R. LEXINGTON PARK ST.MARYS RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington D.C. 1 YES 2 | NO permit. FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 16 53rd Street, S.E. 20019 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, alc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: Black BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 3 Computer Specialist D.C. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) H Winfred Peay, Sr. BE Annie Catlett notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Sandra Peay (Wife) 203 Royal Oak Circle Landover, Maryland 20785 hours after death. Page 6 may be Pe 20a. METHOD OF DISPOSITION
1 X Burial 2 ☐ Cremellon 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Fort Lincoln Cemetery Donation 5 - Other (Specify) 1995 June 3. Brentwood, Marvland 22. NAME AND ADDRESS OF FACILITY Rollins Funeral Home, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner filled in by the fi 4339 Hunt Place, N.E. Washington, D.C. 20019 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or has Interval Between completely filled in IMMEDIATE CAUSE (Final Onset and Death the disease or condition ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) traumatic event. P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF)requires that the death certificate be executed in and com to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a ental Hygiene prior to If any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury other QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the after DIVISION OF VITAL RECORDS, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s, WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS by t AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? COCAINE USE amy Signed Health a 1 YES 2 - NO shows ES 2 NO Deen I. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item certificate to the State HOSPITAL: OTHER: 1XXES 2 NO Inpetient 2 X ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 0 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF marked, this with 1 (X) Natural 5 Pending м 1 YES 2 NO BY After death 2 Accident 28s. PLACE OF INJURY — At home, farm, streel, lectory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 6 Could not be after 28 DIRECTOR: 4 Homicide DOUTS Item 1 \_ CERTIFYINO PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as atteted. TO THE HOSPITAL DO THE FUNEDAL CO THE FUNEDAL CO THE WITHIN 72 TO THE WITHIN 72 TO THE WITHIN THE BEST OF THE PROPERTY. HOSPITAL 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurs at the time, data and place, and due to the cause(a) and menner as stated. 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE PRA O.C.M.E .1995 2 CAUSE OF DEATH (ITEM 27) / Type: Print 111 PENN STREET BALTIMORE, MARYLAND 0 21201 J. HEGISTHAN'S SIGNATURE 31. DATE FILED /A

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be neitfied at once.

	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAI CERTIF	RTMENT OF	HEALTH	AND M	ENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last) Gwendolyn Pough		-				2 DATE OF DEATH	17 95	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER	24 MDS	7. DATE OF BIRTH		3:00a M
	242-26-5644		72 YRS.	MONTHS DAYS	HOURS	MING.	(Month, Day, Year) 08-31-22	Cour	ntry)
1	9a. FACILITY NAME (If not institution, give a		72	9b. CITY, TOWN	OR LOCATIO			9c. COUNTY OF	ford, NC
DIRECTOR	Bay Meadow Nursin	ng & Rehab	Ctr	Glen Bu				Anne Arı	
E S	10e. STATE 10b. COUNTY	γ	10c. CI	Y, TOWN OR LOCA	TION				10d. INSIDE CITY
	Maryland Anne	Arundel	Gler	Burnie					LIMITS?
FUNERAL	7355 Furnace Bran	ich Road			4. ZIP CODE 21060				WHAT COUNTRY?
N	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED			F HISPANIC	ORIGIN? (Specify Yes	Or No.— 14 BA	CE — American Indian.
	1 Never Married 2 Married	FORCES? 1 Y		Il yes, s	ecify Cuban	n, Mexican,	Puerto Rican, etc.)	Ble	ck, White, etc.
BY	3 Wildowed 4 Divorced				X	apaciny.		Spo	BLACK
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	WORL OCCUPATE work done during m se retired.)	ON ost of working	g	16b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sewing M				6		
ME	10th grade		pewing r.	actiffie (	-			ng Facto	ory
	John Galbreight				Graha		E (First, Middle, Maiden :		
BE	19n. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDRESS (Stant			Mary Emm ute Number, City or Town		
임	Christine Garriso	n	900 ₺	KX Galet	own D	rive.	, Severn,	Md 2114	4
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION /N	ame of			CATION — City or 1	
	1)XBurial 2 Cremation 3 Remarks Donation 6 Other (Specify)	oval Irom State	cometery, crematory or of WOOd Taw	n Cemete	ery	5/			1101 011
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY								
	J'Am W L	strug Ox	Mier	Ly in	SI GE	MAN SIL	is osume	was well	m det,
	23. PART i. Enter the diseases, or o shock, or heart fellure.	complications that cau	sed the deeth. Do	not enter the me	de of dylr	ng, auch	as cardiac or reaple	retory arrest,	Approximata
1 1	IMMEDIATE CAUSE (Finel	A	40/1-	21					Interval Between Onset and Death
	disease or condition resulting in death)	. /4	etastatio	e Tudo	mo Ca	rcu	oma		2 yes
		DUE TO (OR A	AS A CONSEQUENCE O	F):					U
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	IS A CONSEQUENCE O	F):					
S	cause. Enter UNDERLYING	e.							
E	CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):					
E	reaulting in death) LAST	d							
ايا	PART II. Other algnificent condition	a contributing to deet	h but not resulting	in the underlyin	g ceuse gi	Iven in Pa	art I, 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
ই	Clarine Ce	mal faile					PERFORI		AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	Mosthe	roid ich					1 TES 2	MA NO	OF DEATH?  1 YES 2 NO
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YI	S NO [	UNC	ERTAIN			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only one)					
YSIG	1 D YES 2 NO	HOSPITAL: 1   Inpetiant 2   ER/C	Outpetient 3 🗆 DOA	OTHER: 4 Nursing Hor	10 5 🗆 Res	idence 6	Other (Specify)		
	27. MANNEB OF DEATH  1 Netural 5 Pending	26a. DATE OF INJUI (Month, Day, Yea		IURY WO	URY AT ORK? YES 2		ed. DESCRIBE HOW IN	JURY OCCURED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJU building, atc. (5	JRY — At home, larm,				181. LOCATION (Street as City or Town, State)	nd Number or Rural	Route Number,
ETE	4 Homicide datermined						ony or nown, orang		
COMPLET		CIAN: To the best of my kr							a) and menner as stated
ECC	296. SIGNATURE AND TITLE OF PERPIFTER					NSE NUMBI			D (Month, Day, Year)
TO BE	Meto	/	17		D	275	569	► 571°	7195
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	Print)	Pi	ten	town Rd	#30	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S		1 1 1	100	1000	100		
	MAY 301995 del	MA is a							
		The water of the	4.1.11						

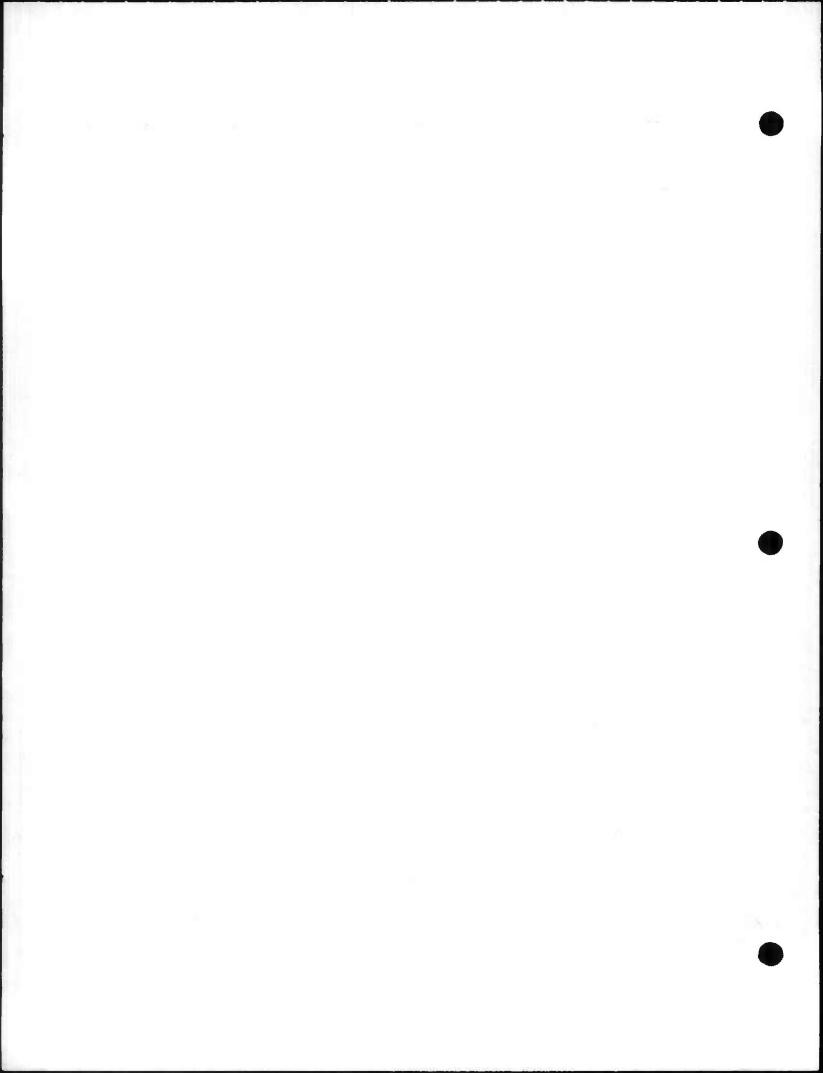
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5-s hours after death. Page 6 may be retained by the hospital or attending physician and completely filted in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE

STATE	0F		<b>DEPARTMENT</b>				MENTAL	HYGIENE
		CE	ERTIFICATE	0	F DEAT	TH		BEG NO

	REGISTRAR		CERTIFI	CATE OF	DEATH	RE	G. NO.					
- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OR			3. TIME OF OEATH			
	WILMA JENKIN	IZ P	OWELL			May 2	2.7 DAY	YEAR	5:08 F			
	4. SOCIAL SECURITY NUMBER		3E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIE	TH	8 BIRTHPI	LACE (State or Foreign			
	231-26-5593	1 🗌 M 2 💢 F		MONTHS DAYS	HOURS MIN.	FEB -	15-1920	Couperu	RGINIA			
_	9a. FACILITY NAME (If not institution, give s		ME		OR LOCATION OF D			NTY OF OE				
ő	FT-WASHINGTON N	ANKZING HO	THE	FT.L	AZHING,	TON	PR]	LNCE	GEORGES			
Б	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	v	40.10									
DIRECTOR		DDLEZEX		PPING	TION				IOd. INSIDE CITY LIMITS?			
A	10e. STREET AND NUMBER			10	1. ZIP CODE		10g. CIT	10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	P-0-B0X 11 F	E.TS			53764			U.Z.	Α -			
3	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Spe	HIC ORIGIN? (Specify Yes or No — 14. RACE -					
7	1 Never Married 2 X Married	FORCES? 1 Y	ES 2X_NO		ocify Cuban, Maxic 3 2 X NO Speci		rtc.)	Black, 1	White, etc.			
ВУ	3 Widowed 4 Divorced				44	-		BL	ACK			
	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S U	JSUAL OCCUPATI	DN	16b. KIND	OF BUSINESS/INC	DUSTRY				
m.	Elementary/Secondary (0-12)	life. Do NOT use	retired.)									
P.		College (1-4 or 5+) 5+	RETIRED	ZCI								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle,	Maiden Sumame)					
BE C	SILVER JENK	ZNI			ANN:	IE KIN	5					
8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street	and Number or Rural	Route Number, City	or Town, State, Zie	Code)				
٩	CORNELIUS POWE	ELL SR.	P.0.	BOX 73	RT - 3 1	TOPPIN	SS VIR	SINIA	4 53764			
	20a. METHOD OF DISPOSITION							ATION — City or Town, State				
1 Ruriel 20 Crametion 3 Removal from State								CHMOND VIRGINIA				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY CENTRAL VA - FUNERAL SER											
Dully Bell P.O.BOX 26528-RICHMON												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	shock, or heart failure.	List only one ceuse or	each line.		, , , , , ,			000,	Interval Betwee			
	disease or condition IICOATIC CETA											
	resulting in death)  e. HEPATIC COMA  48°											
	OUE TO (DR AS A CONSEQUENCE DF):											
S	Sequentially list conditions,  OUE TO (OR AS A CONSEQUENCE OF):											
A	if any, leading to immediate cause. Enter UNDERLYING	00E 10 (0H A	AUSE	17012	1212							
걸	CAUSE (Disease or injury		S A CONSEQUENCE OF		OWN				<del> </del>			
CERTIFICATION	that initiated events resulting in deeth) LAST	A PU) UI 300	S A CONSEQUENCE OF									
50		d							1			
	PART II. Other algnificent condition	a contributing to deet	but not resulting in	the underlyin	g ceuse given in	Part I. 24a. V	NAS AN AUTOPSY	24h. W	YERE AUTOPSY FINDIN			
DICAL	POLYCYTHE		_	•		F	ERFORMED?	A	MAILABLE PRIOR TO COMPLETION OF CAUSE			
		- , , , , ,				— l¹□	YES 2 NO		F DEATH?			
ME	DID TOPACCO LICE CO.	DIDLITE TO CALLE	OF DEATH		7			1	YES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONTI	KIBUIE 10 CAUSE				N 🗆						
ਹ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:								
YS	1 TYES 2 NO	1 Inpetient 2 ER/O			ne 5 🗆 Rasidence	6 Other (Spec	ffy)					
H	27. MANNER OF OEATH	26a. DATE OF INJUR (Month, Day, Yea	Y 26b, TIME		JURY AT	28d. OESCRIBE	HOW INJURY OC	CUREO				
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO							
	3 Suicide 8 Could not be	26e. PLACE DF INJU building, etc. (S	IRY — Al home, farm, st	rest, factory, offic		261. LOCATION	(Street and Number	or Rural Rou	ite Number,			
3	4 Homicide determined					Oily Or IOWII	, SIEIU)					
ا ت	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my kn	owledge death occurred	at the time dete	and place, and due	to the courts)		G.				
(Check only one)  2 MEDICAL EXAMINER: Do the basis of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner ee stated.  2 MEDICAL EXAMINER: Do the basis of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner ee stated.									and menner so stated			
296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE S									fonth, Day, Year)			
2	ge saw	nano	1 (.7)		D296	4-6		2-7	7-95			
	30. NAME AND ADDRESS OF PERSON WH											
	JOEL SEW	CHAND	M. D. 3	600 L	CONARI	NWOTC	RO WI	HODI	CF. HD.20			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE									
	MAY 3 0 1995	Julia Davidson	Nordalle									



2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Roger P. POulnot

5. SEX

4. SOCIAL SECURITY NUMBER

PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zu hours after death. Page 6 may be retained by the ho	ERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact	
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William Dennis

7. DATE OF BIRTH (Month, Day, Year 1947 DAYS HOURS 220-60-7460 1X M 2 | F 48 YRS. Feb. 4, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH Hyattsville Manor Nursing Home DIRECTOR Hyattsville RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN DR LOCATION Hyattsville Prince Georges permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 6500 Riggs Road 20783 ned for use as the burial-transit spital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR DR DATES If yes, specify Cuban, 1 ☐ YES 2 🔯 NO 1 Never Married 2 Married BY 3 Widowed 4 N Divorced Specify: ED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Designer Self Employed once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Paul Poulnot. BE Denise Feraud notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elodie Zinner 6825 Needwood Road, Derwood, Md. 20855 pe 20a. METHOD OF DISPOSITION
1 □ Burlal 2 ☒ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION - City or Town, State must cemetery, cremetory or other place)
Metropolitan Crematory 4 Donation 5 Other (Specify) 5-29 Arlington, Va 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home
4217 9th. St. N.W. Washington, D.C. 20011 examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART / Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest. medicai shock, or heart fallure. List only one cause on 6 **IMMEDIATE CAUSE (Final** the disease or condition event, resulting in death) DUE TO YOR AS A CONSEQUENCE OF traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING other CAUSE (Disease or injury DUE TO JOR AS A CONSEQUENCE OF: that initiated events reauiting in death) LAST 6 injury, MEDICAL but not resulting in the 24a, WAS AN AUTOPSY shows any 1 YER 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | PHYSICIAN: 23 E 25. WAS CASE REFERRED, PO MEDICAL 26. PLACE OF DEATH (Check unly one) item HOSPITAL EXAMINER? OTHER: Inpetient 2 - E9/Outpetient 3 - DOA ing Home 5 [] Residence 8 [] Other (Specify) 6 27. MANNEB OF DEATH 28e. DATE OF INJURY (Month, Day, War) marked, 26c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 1 Natural M I YES 2 NO ВҰ 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office buffiling, atc. (Specify) 3 🗌 Sulcide 99 8 28 4 | Humicide COMPLET item 29а. Сруктичен 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. IMPORTANT: 11 westigstion, in my opinion, death occured at the time, data and placa, and due to the cause(a) and menner as stated. FUNE Withi

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Md. 6500 Riggs Road Hyattsville, Md. 20783

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

6. AGE (In yrs. last birthday)

95 18635

3. TIME OF DEATH 2 28

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 X YES 2 NO

Approximate

Onset and Death

8. BIRTHPLACE (State or Foreign Country)

Avignon France

9c. COUNTY OF DEATH

Prince Georges

USA

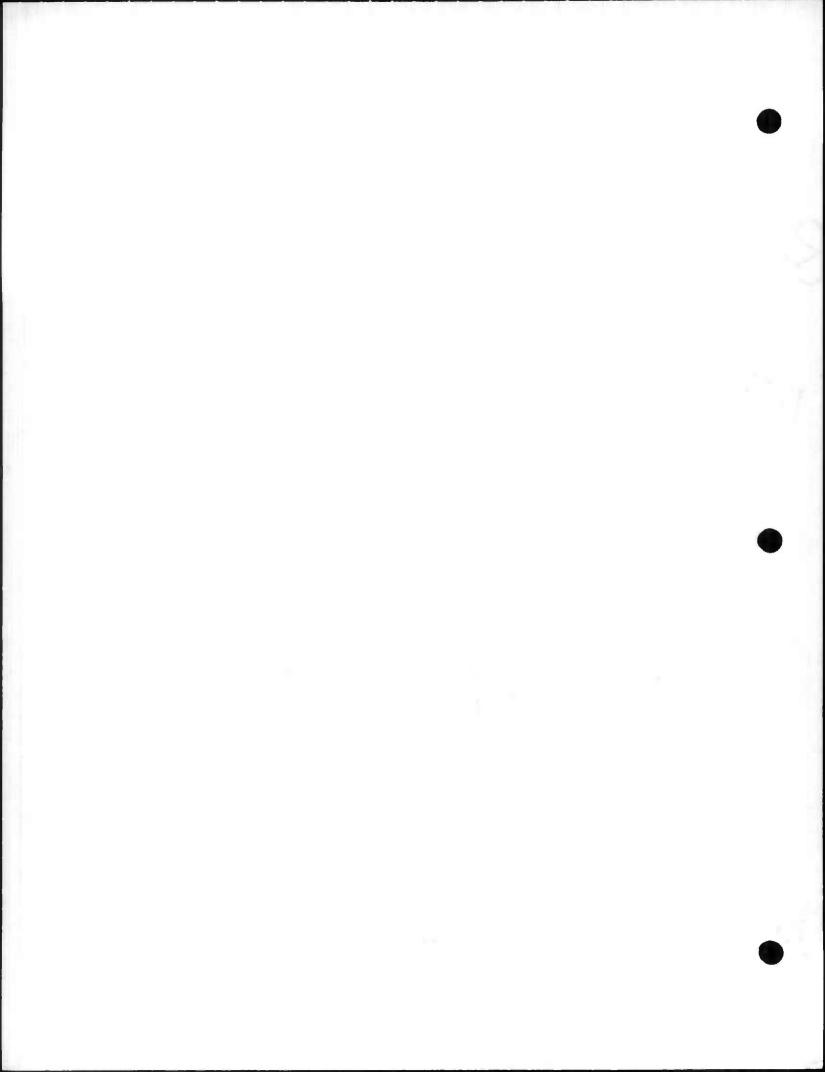
10g. CITIZEN OF WHAT COUNTRY?

White

BM

24s. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHS 1 YES 2 NO 281. LOCATION (Street and Number or Hurel Route Number City or Town, State) 29d. DATE SIGNEO (Month, Day, Year)

Way 27 (99) DHMH-16 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The opposite Distriction of the opposite of
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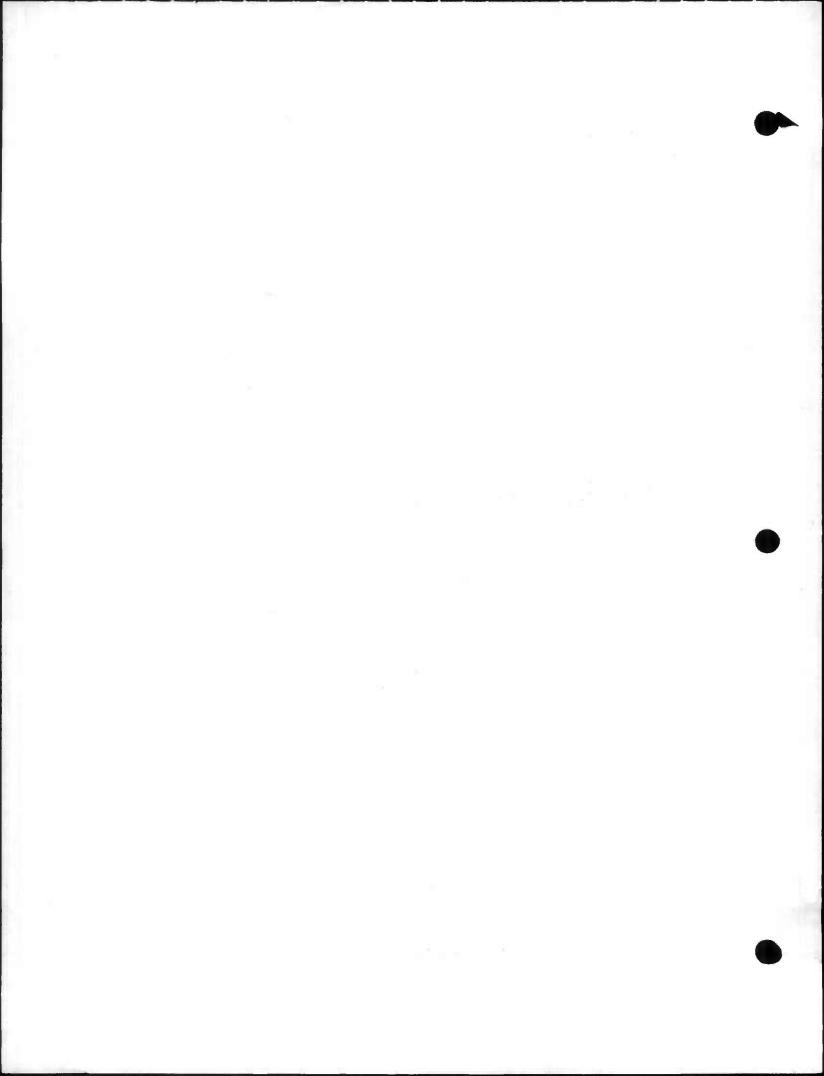
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed withing withings after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. iours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	NEGISTRAN				-17111	CALE	- OF	DEA	i n	HE	G. NO.			
	1. DECEDENT'S NAME (First,		D. 1							2. DATE OF DE MONTH	DAY		YEAR	3. TIME OF DEATH
	ALONZO J 4. SOCIAL SECURITY NUMB	ER	Peeke 5. SEX	6. AGE (In yrs. las	birthdev)	IF UNDER	1 VEAR	IF UNDER	24 HBS	June 7. DATE OF BIR	6	1	995	8:45 A M
	396-07-737	0	1 X M 2 🗆 F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day,	Year)	916	Countr	(Y)
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			May 25 1916 Wisco							EATH	
DIRECTOR	2659 Cory		Wheaton Montgomery								omery			
EG	10a, STATE	10b. COUNTY	,		10c. CIT	Y, TOWN C	R LOCAT	TION						10d. INSIDE CITY
	MD	Mont	gomery		W]	heat	on							LIMITS?
FUNERAL	100. STREET AND NUMBER	Помя						2090						WHAT COUNTRY?
NE I	2659 Cory	rerr										US		
	1 Never Married 2 X	Married	FORCES? 1	T EVER IN U.S. ARI	MED IO		f yes, sp	ecity Cube 2 NO	n, Maxicar	IC ORIGIN? (Spen, Puerto Ricen,	city Yea o etc.)	r No	Biaci	E — American Indian, k, Whita, etc.
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三		Property of the control of the contr		(Gi	CEDENT'S	vork done i	CCUPATIO	ON st of workin	ng	16b. KIND	OF BUSIN	NESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5 -		Do NOT US		Ofi	fice	r	US	Gov	ern	ment	t
NO.	17. FATHER'S NAME (First, M.									ME (First, Middle,			_	
BE (	Louis P.		9							Harri				
5	Anne C. E			198	MAILING 2659	COI	(Street a	rerr	or Rural R	Wheat	on/	State Z	209	02
	20e. METHOD OF DISPOSITE		ovel from State	20b. PLACE A	ND DATE O	OF DISPOS	ITION/Na	ime of		DATE				own, Stata
i	4 Donation 5 Other  21. SIGNATURE OF FUNERAL		ENDES 4	Metro	pol						Alex	cand	ria	VA
1	-M M	11.1	16	0	)			t Mei		al Serv	ices	, Ir	nc.	
-	23. PART I. Enter the di	neen	word	yuc						21401				
	ahock, or he	eart fallure. I	List only one can	me on each line	etn. Do n	iot enter	the mo	ae ot ay	ing, aucr	n aa cerdiac o	r reapira	itory er	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. Caral and Death													
	DUE TO (OR AS A CONSEQUENCE OF):													
ON	Sequentielly list conditi		ter DUE TO	(OR AS A CONSEC	S /	ما	5							2 yrs.
EA	It any, leading to immediate. Enter UNDERLYI	NG	Com	l'a	اسما	cu	le		Q'	Tous	0			10 400
Ē	CAUSE (Disease or Inju that initiated events resulting in deeth) LAS		DUE TO	(OR AS A CONSEC	UENCE OF	ŋ:								
CERTIFICATION	resulting in deeth) CAS		1							<u> </u>				
	PART II. Other significe	nt condition	contributing to	deeth but not r	esylting I	n the un	derlyln	g couse !	given in		MAS AN AL		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL	Chron		0690	met	in	e /	Put	man	-		YES 2			COMPLETION OF CAUSE OF DEATH?
Σ		y 260	use							_				1   YES 2   NO
AN	25. WAS CASE REFERRED TO	MEDICAL					26 Pi	ACE OF D	EATH (Ch	ock only one)				
SIC	EXAMINER?		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	₹:			6 Other (Spec	(Av)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, D		28b. TIM	-	28c. INJ			28d. DESCRIBE	**	URY OC	CURED	
BY		Pending Investigation				M	1 🗆 '	YES 2	NO	-				
COMPLETED		Could not be determined	building.	F INJURY — At ho atc. (Specify)	me, farm, s	street, fact	ory, offic	•		261. LOCATION City or Town	(Street and n. State)	d Numbe	r or Rural I	Route Number,
PLE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	nth occurre	ed at the t	lme, date	and place	, and dua	to the cause(s) s	and manne	or as sta	ted.	
NO.														s) end manner as atated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	1					29c. LICI	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	DEDECTI MAN	> (					DY	1/9	3/		J	une	6, 1995
	2 Shumes	LO- N	1D 230	9 CL	27) (Type,	010	1	0 1	1 11- 0	- 4	n	1	2 ^	903 -
	31. DATE FILED (Month, Day,	(bar)	32. REGISTRA	A'S SIGNATURE	27	2/1	10		che	100	, , - (		20	102
	JUN 0	8 1995	Salin d	Soudles Ra	robally									
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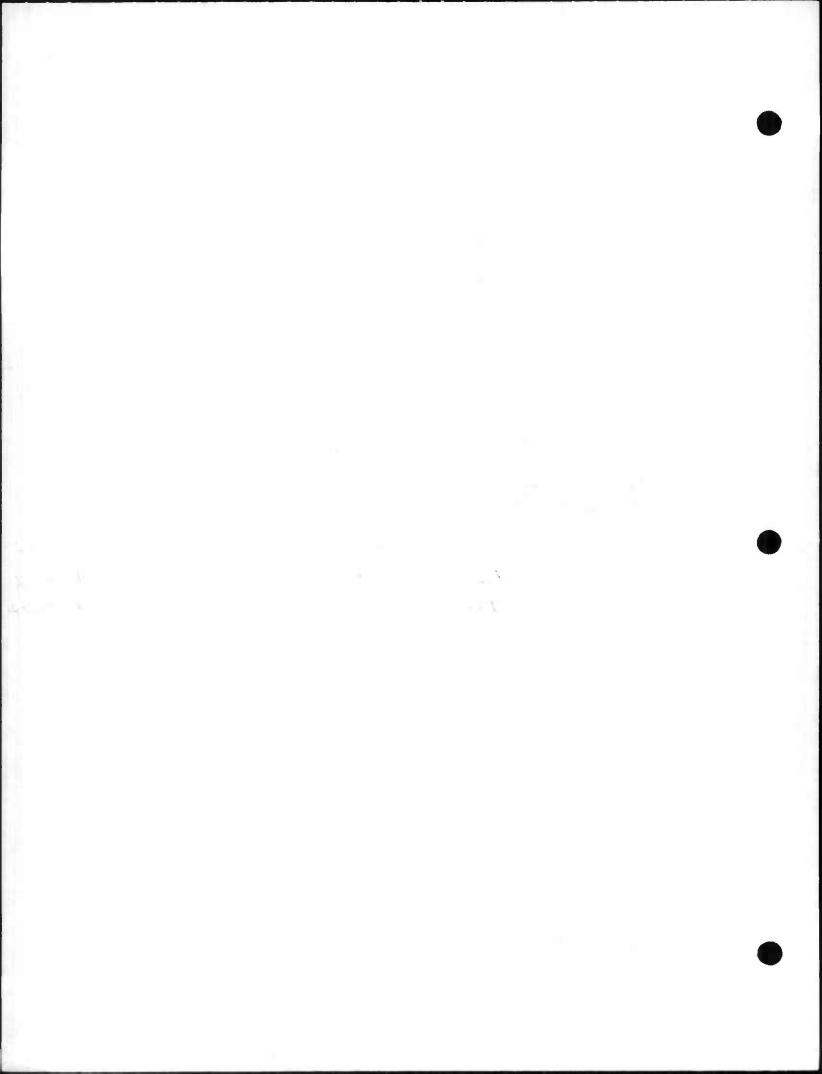
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1 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if led within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or removal.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
10	De 1	IMP

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF					MENTAL HYGIENE				
- 8	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH	
. 13	VIOLET GERTRUDE	PARISH						MAY 27,199	)5	YEAR	8:35 A M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER		IF UNDER 24 I		7. DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign	
Ĭ	233-34-6188		73 YRS.	MONTHS	DAYS	HOURS N	ARN.	Feb 13, 19	22	WV	,	
~	9e. FACILITY NAME (If not institution, give s	street and number)		9b, CITY	, TOWN C	R LOCATION	OF DE	ATH	9c. COUNT	Y OF DE	ATH	
5	Sacred Heart Hos	pital			Cumb	erland			A116	egan	у	
DIRECTOR	10a. STATE 10b. COUNT	Υ	10c. C/1	Y, TOWN (	OR LOCAT	ION					10d. INSIDE CITY	
E	WV Mi	neral		Fort	Ash	by					LIMITS?	
AL	10e. STREET AND NUMBER				101	ZIP CODE			10g. CITIZE		HAT COUNTRY?	
ER	HC 86 Box 25					2671	9		J	J.S.	Α.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED					IC ORIGIN? (Specify Yes	or No- 1	4. RACE	- American Indian,	
ВУ	1 Never Married 2 Married  3 🛱 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES			2 X NO		, Puerto Rican, etc.)		Specify	White, atc.	
	15. DECEDENT'S EDU	ICATION	44- 0505051171	1							ite	
=	(Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done				16b. KIND OF BUSI	NESS/INDU	STRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Hom	emake	er			Own H	ome		ì	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER	'S NAN	AE (First, Middle, Malden S				
BE C	William O. Bor	ror				Eli		0. Stagg				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	S (Street a	nd Number or I	Rural A	oute Number, City or Town,	State, Zip C	iode)		
F	Paul E. Parish		515	Pri	nce	George	St	reet Cumb	erlar	nd,	MD 21502	
	26a. METHOD OF DISPOSITION 1 N Burial 2 □ Cremation 3 □ Ram	eoval from State Con	PLACE AND DATE	OF DISPOS	ITION (Na	me of			ATION — CI		,	
	4 Donation 5 Other (Specify)  21. BIGNATURE OF PUMERIAL SERVICE EX	Ca	netery, crematory or o	-					eyser	, W	V 26726	
	The sound of the service of					k-Smi		илу Funeral Ho	me			
	Alicen 19	ollul		85	Sou	th Ma	in	Street Key	ser,	WV	26726	
	23. PART I. Enter the diseases, or a shock, or heart fellure.	complications that ceused List only one cause on e	the desth. Do	not enter	the mo	de of dying,	auch	aa cerdiec or reapire	itory arrea	nt,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final disease or condition											
	resulting in death)	. Pher	rmou	ra							1 ach?	
		DUE TO (OR AS A	CONSEQUENCE	F):		C 11	_				17 00	
S	Sequentially list conditions,											
SAT	If any, leading to immediate cause. Enter UNDERLYING	Hu	perter	1.51	02	1					17 780	
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OP AS	CONSEQUENCE O	F):							1/2	
CERTIFICATION	resulting in death) LAST	aulting in death) LAST										
	PART II. Other aignificant condition	na contributing to deeth b	ut not resulting	In the un	derlying	ceuse give	n in F	Part I. 24a. WAS AN A	UTOPSY	24b. 1	WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL								PERFORM			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
								1 _ YES 2 @	STATE OF	1	OF DEATH?	
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YI	S 🗆 I	NO [	UNCER	TAIN					
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA									
KSI	1 YES 2 NO	HOSRITAL:	etlant 3 🗆 DOA	OTHER 4 Nun		5 🗆 Reside	ence 8	Other (Specify)				
PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF JURY	28c. INJ WO	JRY AT	Т	28d. DESCRIBE HOW IN.	JURY OCCU	RED		
B	1 Natural 5 Pending 2 Accident Investigation			М		ES 2 N	0					
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm,	streel, fact	ory, office			28f. LOCATION (Street and City or Town, State)	d Number or	Rural Ro	oute Number,	
COMPLETE	AL OFFICIEN											
MPL	(Check only CENTIFYING PHYSI	ICIAN: To the beat of my know										
8	-4	R: On the basis of examination	n and/or investigation	on, in my o	pinion, d	eth occured a	at the t	ime, data and place, and	dua to the	cause(a)	and menner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIES	R				29c. LICENSI	E NUMI	BER			Month, Day, Ybar)	
ဝ	30. NAME AND ADDRESS OF PERSON WH		ATH ATEM OF A	Deleta		00	23	5//	M/	AY _	50-94	
	Uriel Vehndi	AIN an	1501		/- /	n	2.0	land MD	),,	-/1		
	31. DATE FILED (Month, Day, Year)	22, REGISTRARIS SIGN	ATURE	cri	e /	MA	ell	and 141)	2()	000	~	
	JUN 0 2 1995	This Davidson	Rardall									
			_									



3. TIME OF DEATH

Approximate Onset and Death 1 day

1995 1:35 P M

2. DATE OF DEATH

			Anna Mar				_			7 1		May 2	5, 1	995	1:35 P
		1	214-05-837		5. SEX	6. AGE (	ln yrs. last 89		UNDER 1 YE		MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country)	LACE (State or Foreign
3 should		ŀ	9a. FACILITY NAME (If not int		- 21		09		CITY TO	VN OR LOCATION		Jan. 11,		6 Ma	ryland
6,	DIRECTOR		Garrett M	-		pita	11		Dakl		N OF CEAT			ret	
Sages	E		10a. STATE	10b. COUNTY				10c. CITY, To			_				IOd. INSIDE CITY
mit. P		- 10-	Maryland  100. STREET AND NUMBER	Alle	gany			Cumb	erl						YES 2 NO
st pe	RA		510 N. Me	chani	c Stro	ρt				101. ZIP CODE 2150	12		10g. CITIZ	USA	IAT COUNTRY?
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the bunal-transit permit. Pages 1,	BY FUNERAL	- 11	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 X Divor	Married	12. WAS DECEDENT EVER IN U.S. ARMED 13. WA					AS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — yea, specify Cuban, Mexican, Puerto Rican, etc.)					- American Indian, White, etc. White
15- ttendin	ED 8	- 11	15. DECE	EOENT'S EDUCA			16a. DEC	EDENT'S USU	AL OCCUE	ATION		16b. KIND OF BUS	NAME OF TAKEN		
D 212 spital or al			(Specify only Elementary/Secondary (0-	highest grade c	completed)  College (1-4 or 5	+)	(Giv	e kind of work Do NOT use re er/Op	done during lired.)	most of working		Retail	L		
AN the ho	once. COMPL	I	17. FATHER'S NAME (First, Mil	ddle, Last)						18. MOTHE	ER'S NAME	(First, Middle, Maiden		.OI C	
MARYLAND retained by the hospit should be detached	111 S	L	Charles B.		mer							a R. (Yo	_		
	TO BI		Barbara A.	- 101	io							no Number, City or Town			D 21502
RE, nay be page	2		20a. METHOD OF DISPOSITION	ON			PLACEA	D DATE OF D	SPOSITION	_	DC.		CATION - C		
IMOR	r must	IL	1 Donation 8 Other	(Specify)		- Sn	etery, crem nith	sbur	r Cr	emator	cium	5/26 Sn	niths	bur	g, MD
ALT death. f	examiner		21. SIGNATURE OF FUNERAL	SERVICE LICE	ASER CONTRACTOR	)						" Kight F r st., Cu			me MD 21502
n by	medical	7	23. PART I. Enter the dis shock, or he	seases, or co	implications the	it caused	the dea	th. Do not	enter tha	mode of dyln	g, such s	na cardiec or reapi	ratory arre	st,	Approximate Interval Batwee
and below			IMMEDIATE CAUSE (Fine		2000										Onset and Deat
2 4 3			disease or condition		DATETRIO	ATT A									
₩ €	vent, t		disease or condition resulting in death)	<b>→</b> a.	PNEUMO	NIA (OR AS A	CONSEQ	JENCE OF):							1 day
68760. acuted within nd completely	6		resulting in death)	+ a.	DUE TO	(OR AS A									
DX 68760 be executed within cian and completely	6			llata	DUE TO										
. BOX 68760 ficate be executed within physician and completely	6		Sequentielly list condities if any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or injurthat initiated events	NG ry c.	DUE TO	(OR AS A	CONSEQU	JENCE OF):							
P.O. BOX 68760 afth certificate be executed within tending physician and completely Mariene proc to build processing	or other traumatic er		Sequentielly list condities if any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or injurt that initiated events resulting in death) LAST	lieta NG ry c.	DUE TO	(OR AS A	CONSEQU	JENCE OF):							
ADS, P.O. BOX 68760 it the death certificate be executed within the attention physician and completely active the attention physician and completely better the attention physician and completely active the attention physician and completely active the attention to the attention and active the attention attention and active the attention and active the attention and active the attention and active the attention attention and active the attention and active the attention and active the attention attention and active the attention attention and active the attention at	injury, or other traumatic er.		Sequentially list condition if any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or injurt that initiated events resulting in death) LAST	lista NG ny d.	DUE TO	(OR AS A	CONSEQUENCE CONSEQ	JENCE OF): JENCE OF): suiting in the				ort I. 24a. WAS AN. PERFORI		A	1 day
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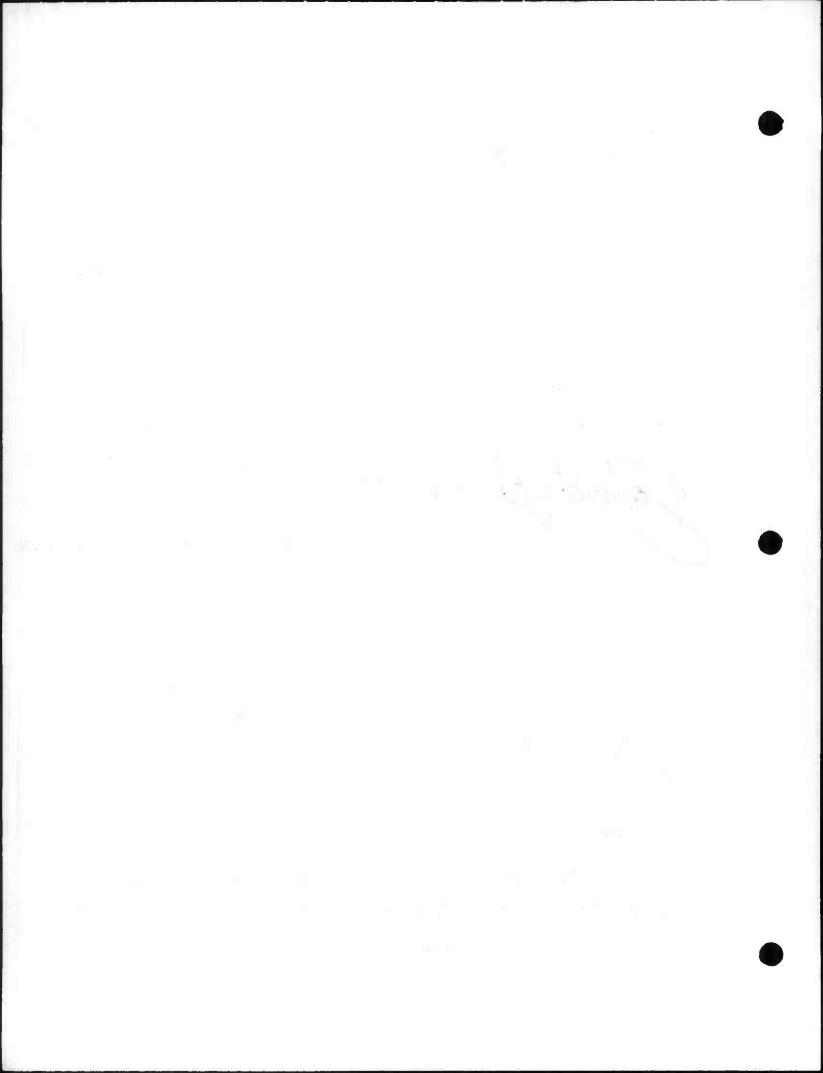
Walter K. Naumann, M.D., PO Box 247, Accident, MD 21520 32. REGISTRANS SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

		1 - STATE OF MARYLAND / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPART	TE DEATH	HYGIENE REG. NO.	
2		1. OECEDENT'S NAME (First, Middle, Last)  VIVIAN L. OUIGG	2. DATE OF MONTH		3. TIME OF DEATH
should		378 4 5080 10 m 2 pc 68 YRS.	AR IF UNDER 24 HRS. 7. DATE OF (Month, L)  WHO OR LOCATION OF DEATH	BIRTH 8. (20), (bar) 9. (22 1926	BIRTHPLACE (State or Foreign Country)  W. Virginia
1, 2, 3	СТОВ	Anne Arundel Medical Center	Annapolis		e Arundel
permit. Pages	DIRE	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR L  Maryland Anne Arundel Se	verna Park		10d. INSIDE CITY LIMITS? 1 YES 2 NO
黃	FUNERAL	211 Sycamore Road	10f. ZIP CODE 21146		OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	B	1 Never Married 2 Married FORCES? 1 YES 2 NO If ye	DECENDENT OF HISPANIC ORIGIN? (i b, specify Cuben, Mexican, Puerto Rice YES 2X NO Specify:	an, etc.)	RACE — American Indian, Black, White, etc. Specify:
5 2	LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during life. Do NOT use retired.)  Elementary/Secondary (0-12)  College (1-4 or 5 +)		IND OF BUSINESS/INDUST	Caucasian
YLAND by the hospital be detached to at once.	E COMPL	12+ Secretar  17. FATHER'S NAME (First, Middle, Lest)  Lowell Hanback	18. MOTHER'S NAME (First, Mide	the same of the sa	tate Covit
MAR retained 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (St.	Velma Joh  oot end Number or Rural Route Number,  ore Road Seve	City or Town, State, Zip Coo	
MORE e 6 may rector, pa		20e. METHOD OF DISPOSITION  SO Burlel 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITIO  commetery, crematory or other place)	N(Name of DATE	20c. LOCATION City	
death.		21. SIGHANDRE OF FURERAL SERVICE LICENSES APLINSTON N 22. AND BA 49	e and address of facility rranco & Sons 5 Ritchie Hwy	Funeral	Home
to within 24 hours after of completely filled in by the idid, cremation, or removal.		RT I. There the diseases, or complications that caused the deeth. Do not enter the phock, or heart failure list only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the consequence of condition as the condition as th	mode of dying, such as cardiac	c or respiretory arrest,	Approximate Interval Between Onset and Daath
be executed cian and corrior to burial, raumatic or	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury			
ending of other	CERTIF	that initiated events resulting in death) LAST  d			
signed by the Health and Mily	MEDICAL	PART if. Other significant conditions contributing to death but not resulting in the under		Le. WAS AN AUTOPSY PERFORMED?  YES 25 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL MI s law red has been Dept. of 23 sh	AN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO			1 TES 2 NO
_ F 2 2 5 1	PHYSICIAN:	EXAMINER?  1 VES 2 NO  HOSPITAL: 1 A Inpetient 2 ER/Outpatient 3 DOA 4 Nursing	Home 5 Reeldence 8 Other (S		
D F S S S S	BY	1 Netural 5 Pending (Month, Dey, Yeer) NJURY M 1 2 Accident Investigation 25e PLACE OF IN HIPLY At home form street forces.	WORK?  YES 2 NO	ON COLUMN OCCURE	
DIVISION DIVISIONS DIRECTOR: After hours after deat item 28 is ma	LETED	4 Homicide determined building, etc. (Specify)	City or T	ON (Street and Number or R fown, Stete)	urai Houte Number,
Z Z Z =	COMPLET	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, one) 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion			use(a) and menner as stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296. SIGNATURE AND TITLE OF CONTIFIED	29c. LICENSE NUMBER	29d. DATE SIG	NEO (Month, Day, Year)
	,	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  EW COLE GOD BESTGATE  31. DATE EN EN (Aport) Our Mark	ANNAPOLI	S Md =	21401
		JUN 09 1995 July Deviler Royal			



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31. DATE FILED (Month, Day, Year)

MAY 30 1995

32. REGISTRAR'S SIGNATURE

G PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	fler this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Places 1, 2 shows	ior to burial, cremation, or removal.	Parentally account the manufact accommission manufacts at any section of the section of
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execut	# X	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT if ham 28 is marked or ham 23 shows any things or other trainmails avent the madical avenuates he seemed as a seemed to the second of the second o

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 1995 Margaret Renner 25 May 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
Oct. 15, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or For 78 DAYS HOURS 225-10-4810 1 M 2 K F YRS. 1916 Delaware 9e. FACILITY NAME (If not institution, give stre 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2921 N. Leisure World Blvd. Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2921 N. Leisure World Blvd. 20906 USA 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

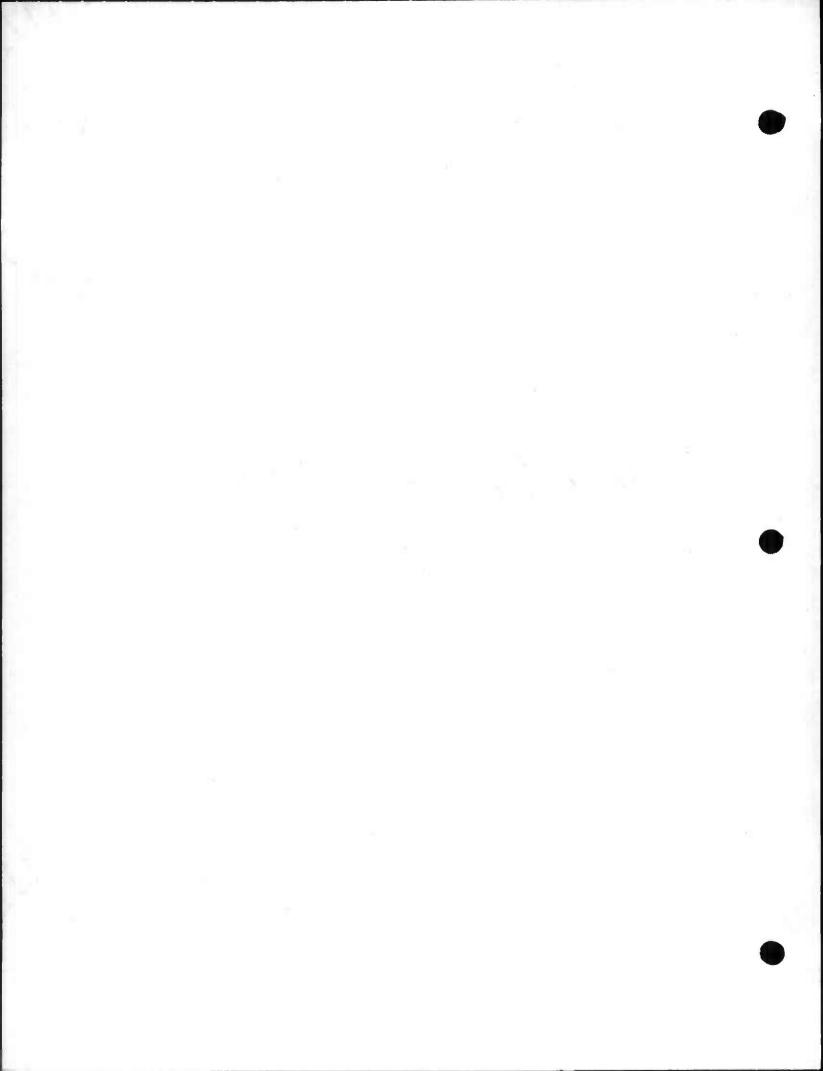
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married В 3 🔯 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 0 Controller Hyman's House of Fashion 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Edward H. Merchant Bertha Belle Tharpe BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward N. Renner 14014 Castaway Drive, Rockville, Maryland 20s. METHOD OF DISPOSITION
1 1 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — Cify or Town, State DATE Edgenill Cemetery 4 Donation 5 Other (Specify) 5/29 Charlestown, West Virginia 21. SIGNATURE OF UNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY EVERLY-Wheatley Funeral Home 1500 West Braddock Road Alexandria, Virginia 22302 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onaat and Death disease or condition reaulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 ☐ YES 2 ☐ NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home Rasidence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 85 May 5 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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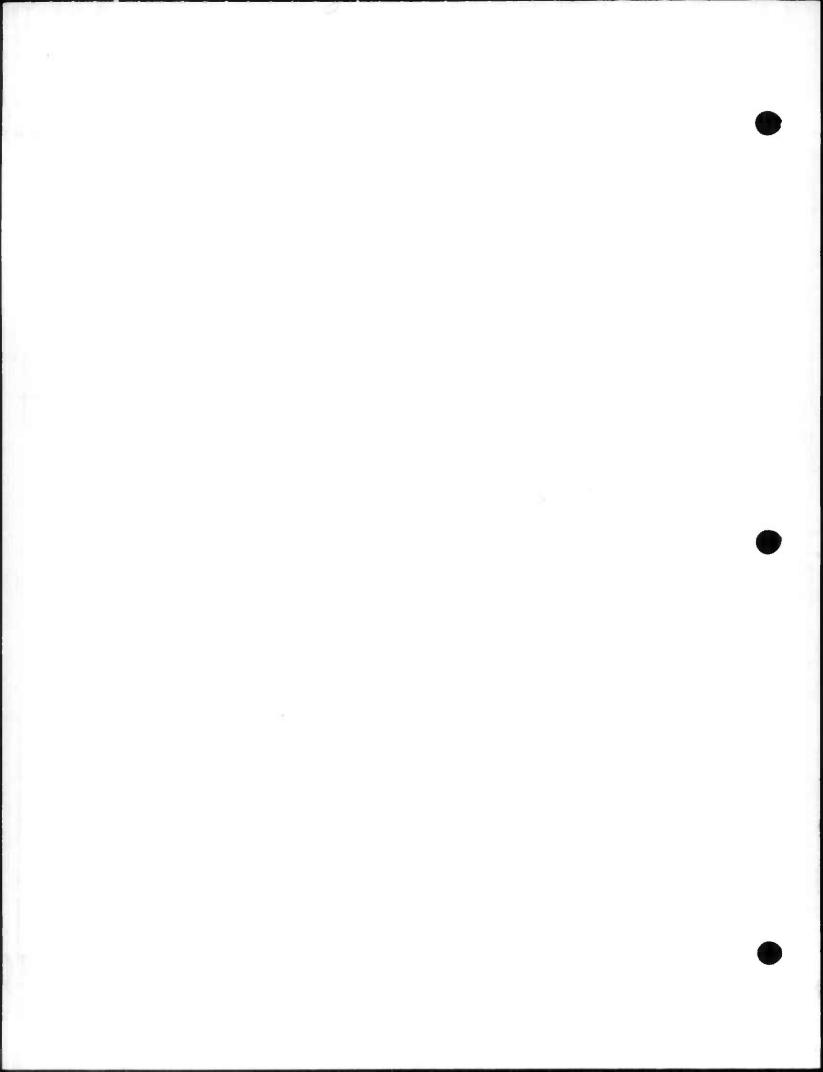
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hours after death. Page 6 may be retained by the hosp	d in by the funeral director, page 5 should be detach or removal.	medical examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF I	/ MARYLAND CE	DEPAI ERTIF	ICAT	T OF H	DEAT	AND I	MENTAL	HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, La.	st)					-		2. DATE O	F DEATH			3. TIME OF DEATH
	EDNA			R	OSENI	BERG			MAY	29	19	995	9:50 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF	BIRTH Day, Year)		8. BIRTHI	PLACE (State or Foreign
	578-56-7058	1 🗌 M 2 💢 F	92	YRS.					JULY		902		. DC
Œ	90. FACILITY NAME (If not institution, given 1401 BLAIR MI		722				R LOCATIO		EATH			NTY OF DE	
5	RESIDENCE OF DECEDENT		- 1 4 4		21	rrver	SPF	CING			MON	NTGOM	ERY
DIRECTOR	10e. STATE 10b. COU			10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
		GOMERY		S	LLVE	R SPI	RING						1 X YES 2 NO
RAL	100. STREET AND NUMBER 1401 BLAIR MILL	DOAD #170				101	ZIP CODI				10g. CIT	ZEN OF W	HAT COUNTRY?
FUNERAL	11. MARITAL STATUS		Z IT EVER IN U.S. ARI				2091						TATES
B	1 Never Married 2 Merried 3 Widowed 4 Divorced		YES 2 XN			If yes, spe		n, Mexica	NIC ORIGIN? in, Puerto Ric y:		or No—	14. RACE Black, Specif	— American Indian, White, atc.
	15. DECEDENT'S E (Specify only highest gra	DUCATION ide completed)	16e. DE6	CEDENT'S	USUAL O	CCUPATIO	N st of workin	a	16b. K	UND OF BUS	SINESS/INC	OUSTRY	
	Elementery/Secondary (0-12)	College (1-4 or 5	+) [				st of working	9					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			STAF	F SUI	PERV				WHITE		SE	
	JACOB ROSENBERG						.11-	COL	ME (First, Mic	ldle, Meiden	Sumeme)		
BE (	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRES	S (Street a			Route Number	City or Town	n. State. Ziz	Code)	
2	BARBARA ADLER (1	NIECE)							EVY CH				
	209 METHOD OF DISPOSITION 1 \( \text{D}\) Burlet 2 \( \text{Cregin ion } 3 \) Re 4 \( \text{Donation } 5 \) Other (Specify)	moval from State	A 20b. PLACE A	ND DATE	OF DISPOS	SITION /Na	me of		OATE			Cify or Tov	vn, State
	4 Donation 5 Oner (Specify)		OHEV	SHO				_		WASH	HINGT	ON,	DC
	21. SIGNATURE OF TOTAL SERVICE.	Tr. Y	Lie		DA	NZAN		·GOLI	DBERG				ELS, INC. MD. 20852
	23. PART I. When the disease of shock, or heart talking	r complications the	t caused the dea	ath. Do									Approximate
	IMMEDIATE CAUSE (Final	e. List Only One Cat	L .		1								Interval Between Onset and Death
	disease or condition resulting in death)	. 1-10	eclensio	ا ب	ea	ut	WI	Jea	re				1540
		DUE TO	(OR AS A CONSEC	OUENCE O	F):								,
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO	(OR AS A CONSEC	UENCE O	F):								
S	cause. Enter UNDERLYING	c											!
	CAUSE (Disease or Injury that Initiated events resulting in death) LAST												
H	d.												
CAL	PART II. Other significent conditi	ons contributing to	deeth but not re	suiting	in the ur	derlying	ceuse g	lven in	Part I. 2	4a. WAS AN			WERE AUTOPSY FINDINGS
										YES 2			AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME									_	•			1 TES 2 NO
AN.	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA					UNC	ERTAIN	<u>ا ۵ ۷</u>				
PHYSICIAN: MEDI	EXAMINER?	HOSPITAL:			TH (Check	7:							
HYS	27. MANNER OF OEATH	28e. DATE OF	ER/Outpatient 3 INJURY	28b. TIM	E OF	28c. INJU		sidence	8 Other (S	Specify)	LIURY OC	CURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, D	lay, Year)	IN.	M M	WOI		NO					
	3 Suicide 8 Could not b	28e. PLACE O building,	F INJURY — At hon atc. (Specify)	ne, ferm,	ntreet, fect	ory, office			281. LOCAT City or	ION (Street e Town, Stele)	nd Number	or Rural Ac	oute Number,
COMPLETED		YSICIAN: To the best of NER: On the beele of a											and menner se stated.
ш	296. SIGNATURE AND TITLE OF CENTIF	SER /				T	29c. LICE	NSE NUM	IBER .		29d. DATI	E SIGNED	Month, Day, Year)
10 B	36. NAME AND ADDRESS OF PERSON V	COMPLETED CALL	SE OF DEATH SITEM	27) /Tone	Print		DC.	246	0		<b>&gt;</b> 5	5/30	195
ı	RICHARD SCHOENF	ELD, MD 5	530 WISC	ONSI	N AV	E.#	1445	CHE	VY CH	ASE.	MD 20	0815	
	MAY 31 1991	32. HEGISTHA	R'S SIGNATURE										
		1)	entern in had	-	<del></del>								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

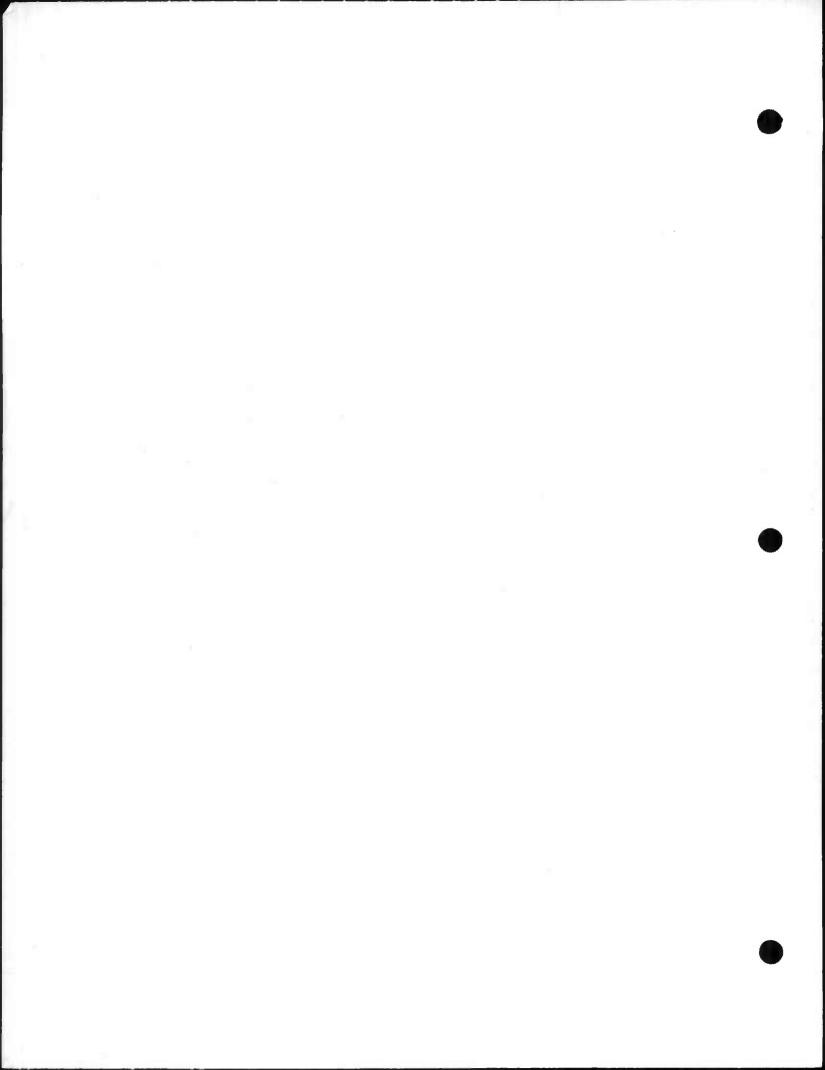
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- (	t. DECEDENT'S NAME (First, Middle, Las								2. DATE O	F DEATH			3. TIME OF DEATH
		SKIND							May 2	24, 19		YEAR	6:20 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE O			8. BiRTH	PLACE (State or Foreign
1 8	013-05-2112	1 🗌 M 2 💢 F	86	YRS.	MONTHS	DAYS	HOURS	Mille.	May :	1, 19	09		ussia
m	9a. FACILITY NAME (If not institution, give				9b. CITY	TOWN	OR LOCATIO	ON OF DE	ATH		9c. COU	NTY OF DE	
5	Hebrew Home of G	reater Wa	shington	n	Roc	kvi	lle				Mor	tgom	ery
E C	10a. STATE 10b. COUN	TY		10c. CITY	, TOWN C	R LOCA	TION						10d, INSIDE CITY
PIG	Florida Brow	ard		Mar	gate								LIMITS?
AL AL	10e. STREET AND NUMBER			7	90.00		f. ZIP CODE	E			10g. CIT	IZEN OF W	THAT COUNTRY?
E	3231 Holiday Spr	ings Blvc	١.			3	3063				Un	ited	States
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN	TEVER IN U.S. AF	RMED	13. 1	MAS DEC	ENDENT O	F HISPANI	IC ORIGIN?	(Specify Yes	or No-		- American Indian, White, etc.
34	3 Wildowed 4 Divorced	IF YES, GIVE Y	AR OR DATES				2 NO			een, etc.)		Specif	у:
	15. DECEDENT'S ED	UCATION	16a DE	CEDENT'S (	ISLIAL O	SUBATI	ON		400.0	UNO OF BUS		White	e
COMPLETED	(Specify only highest grade (Specify only highest grade (Specify only highest grade)	College (1-4 pr 5	(G	ive kind of w	ork done d	during me	st of workin	g	160, 8	UNO OF BUS	INESS/INC	DUSTRY	
립	12	Conege (1-4 b) 5		creta	rv					Jnknov	wn		
Ö	17. FATHER'S NAME (First, Middle, Last)				7		18. MQTH	IER'S NAM		Idle, Maiden			
BE	Charles Slotnic	:k					Sar	ah P	Pinkov	witz			
TO E	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Number	or Rural Re	loute Number	City or Town	, State, Zip	Code)	
-	Susan Luger		1	3715	Wago	n W	ay,	Silve	er Spi	ring,	MD 2	20906	
	20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Rev	moval from State	20b. PLACE cemetery, cre	motory or oth	ar placel				DATE			City or Tov	
	4 Donation 5 Other (Specify)	center /	-   Star	of Da	vid	Mem	orial	Gdn	115/2	d N.	Laud	erda]	le, Fla.
	h _ //	0011								es, F			
_	Doff- 1	SILM	M0082		93	3 G	st A	venu	e. Si	lver	Spri	ng, I	MD 20910
	23. PART I. Enter the diseases, or shock, or heart fellure	complications that List only one ceu	t caused the de	eth. Do no	ot enter	the mo	de of dyi	ng, such	ss cardis	c or respi	ratory an	rest,	Approximats interval Between
	IMMEDIATE CAUSE (Final												Onset and Death
	disease or condition resulting in death)  a. APRYTHMIAS  OUE TO (OR AS A CONSEQUENCE OF):										MINUTES		
			COR AS A CONSE	,		CD.		11.2	ASF				
<u>0</u>	Sequentially list conditions, if any, leading to immediate		OR AS A CONSE				1	2120	1130				YEARS
8	cause. Enter UNDERLYING CAUSE (Disease or injury	6											1
E	that initiated events	OUE TO	(OR AS A CONSEC	QUENCE OF)	:					-			
CERTIFICATION	resulting in death) LAST	d											
١	PART II. Other significant condition	ns contributing to	desth but not r	esulting in	the un	deriying	ceuse g	iven in P	Part i. 2	4a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL										PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä									_   ,	YES 2	DO NO		OF DEATH?  1 TYES 2 X NO
- 13	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YES		10 🖸	UNC	ERTAIN					1 1 123 2 W 110
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		E OF DEATH	(Check o	nly one)							
YSI	1 TYES 2 NO	1   Inpatient 2	ER/Outpatient 3		OTHER		e 5 🗆 Res	sidence 6	Other (S	Specify)			
표	27. MANNER OF DEATH  1 X Natural 5 Pending	28a. DATE OF (Month, De	INJURY sy, Year)	28b. TIME INJU		28c. INJ WO	URY AT RK?		28d. DESC	HE HOW IN	JURY OCC	CURED	
B≼	2 Accident Investigation	20- 51-05-0	F IN HARM		М		ES 2						
	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At ho etc. (Specify)	me, tarm, sti	reet, facto	ry, offici			28f. LOCATI City or	ION (Street a: Town, State)	nd Number	or Runal Ac	oute Number,
COMPLETED	29a. CERTIFIER 1 X CERTIFYING PHYS	101111 7 11 1 1 1											
₽ I	(Uneck only												and manner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE			- genon						ra praca, and			
BE		van M.D.						NSE NUMB	SER				Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON W	ALCOHOL:	E OF DEATH (ITER	# 27) (Type, F	Print)		D365	052			Ma	ay 24	1995
	P. Talwar, M.D.					kvi	۵۱ ا	MD 2	U8E2				
	31. DATE FILED (Month, Day, Year)	6121 Mo	R'S SIGNATURE		NUC	IVV	110,	ב עויו	.0052				
	MAY 31 19	95 Juli	Aburleant	2 1 11									
			-	THE PERSON NAMED IN									DHMH-18 Bev 1/89



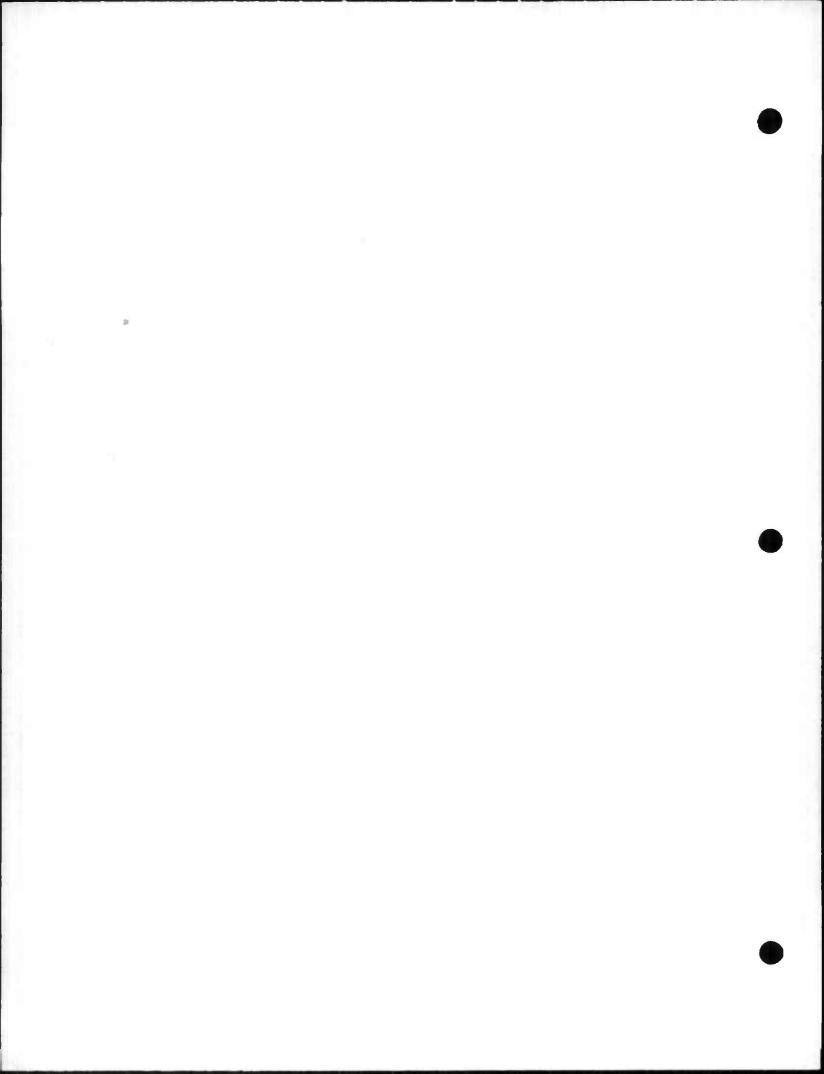
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR			CERTIF	ICATE	OF	DEAT	Ή	F	EG. NO.			
		t. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF		-	3. TIME OF	DEATH
		Rose Dorothea	Reid							May 2	5. 199	YE.	6:50	A M
		4. SOCIAL SECURITY NUMBER		6. AGE (In yr	s. lest birthday)	IF UNDER 1	YEAR	IF UNDER 2	24 HRS.	7. DATE OF I			DIRTHPLACE (State	or Forming
		019-18-7466	1 🗆 M 2 🖵 F		73 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De		C	Country)	
3 should		9a. FACILITY NAME (If not institution, give st	reet and number)		13	9h CITY	TOWN O	PR LOCATIO	N OF DE	Sept.	7 7 7 7	Ma Me. COUNTY	ssachus	etts
38	Œ									AIII	1,	E. COUNTY	JF DEATH	
ci ci	СТОВ	Washington Advent	ist Hospi	tal		Ta	akon	na Pa	rk			Mon	tgomery	
es 1	) E	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCAT	ION	-			7.5-2-2	10d. INSIDE	CITY
T.	DIRE	Maryland Prince	Georges			11		-211-					LIMITS	
im it		10e. STREET AND NUMBER	Georges			пуат		zille			Τ.	A- CITIZEN	t YES	77
physician. burial-transit permit. Pages 1,	FUNERAL	1415 Legation Roa	a a									og. CITIZEN	OF WHAT COUNTY	477
tran-	=	14.13 Legal Lon Koa	12. WAS DECEDENT	EVER IN II C	ADMED	1		2078:				USA		
physician. burial-tran		1 Never Married 2 Married	FORCES? 1	YES 2	NO	lf :	yes, spe	ecify Cuban,	, Maxican	IC ORIGIN? (S		No- 14.	RACE — American Black, White, stc.	Indian,
	E I	32 Widowed 4 Divorced	IF YES, GIVE WA	R OR OATES		1 [	YES	2 X NO	Specify:	:			Specify:	
as as	<u>a</u>	15. DECEDENT'S EDUC	CATION	164	. DECEDENT'S	Hellat occ	MIDATIO	· ·		400 900	D 05 DH0H	ESS/INOUSTI	White	
_ >	IEI	(Specify only highest grade	completed)		(Give kind of a	work done du			7	100. KIN	D OF BUSIN	ESS/INOUSTI	ey.	
hospital o ached for ce.	1 2	Elementary/Secondary (0-12)	College (1-4 or 5 +)	١, ١		66.0								
the hos detach	COMPLET	17. FATHER'S NAME (First, Middle, Last)		IAC	lminist	rator				Libr				
by the hospit be detached at once.										ME (First, Middl	e, Maiden Sur	mame)		
d bed b	BE	Joseph Melvill  19a. INFORMANT'S NAME (Type/Print)	<u>e</u>					Rose		McCox				
5 should notified	일				l					loute Number, C	City or Town, S	State, Zip Code	D)	
y be		Linda R. Murray			8233	New H	lamp	shire	e Av	enue	Adelp	hi Ma	ryland ?	20783
death. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION  1 Neurial 2 Cremation 3 Remo	oval from State	cometen	CE AND DATE (	than alegan				OATE			or Town, Stata	
ge 6 lirect		4 Donation 5 Other (Specify)		Gate	of He	aven	Cem	etery	y 5/	31/95	Silve	r Spr	ing Mary	land
oral c		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. N/	AME AN	O ADDRESS	S OF FAC	YTLIK				
		Mames & &	Loted										e, Inc.	
		23 PART I Sher the disease or complications that squad the death of the state of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the death of the squad the squad the death of the squad the s												
ours after d in by th or remove		ahock, or haart fallure. List only one cause on each line.  Approximate interval Between												
filled fion, o		IMMEDIATE CAUSE (Final disease or condition												
within 24 npletely fille cremation, vent, the	] ]	resulting in death)			lerosi								30	years
8 9 2 . 0	1 1	Sequentially let conditions.  Non insulin dependent Diabetes Mellitus												
at price	N N	Sequentially list conditions,	Non	119	sulin	alpi	end	ent	Ji	abetes	lile	11: tus		
be existed or to	CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	OUE TO (O	AS A COL	NSEQUENCE OF		.0							
physician ne prior to	5	CAUSE (Disease or Injury	[707	ratio		thrit	17.							
nding phys Hygiene p		that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
23 40 -	1 1 1	d d	ı								_			
e 4 2 =		PART II. Other algnificant conditions	contributing to d	eath but n	ot resulting i	n the und	erlying	cause ob	ven In F	Part I 24a	. WAS AN AU	mey T	24b. WERE AUTOP	TW FRIDAIGE
the part of	EDICAL						···,g	occoo gi		unt II.	PERFORME		AMAILABLE PI COMPLETION	HOR TO
9 5 5 6										_   10	YES 2	NO	OF DEATH?	DF CAUSE
5 " 1 2	Σ	DID TODA COO LIST CON ITE											1 TYES 2	□ NO
law law bept 23	PHYSICIAN:	DID TOBACCO USE CONTR	RIBUTE TO CAU					UNCE	RTAIN					
N: The ficate h State (	호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. F	PLACE OF DEAT	H (Check on								
icians ertific the S	ΥS	1 TES 2 NO	t Ø Inpatient 2 □ E	R/Outpatier	H 3 DOA			5 🗆 Resi	idenca 6	Other (Sp	ecify)			- 24
	PH	27. MANNER OF DEATH	26a. DATE OF IN (Month, Day,	iJURY Year)	26b. TIM	E OF 2	Bc. INJU			26d. DESCRIE	BE HOW INJU	IRY OCCURE	D	
After this death with smarked	À	t Matural 5 Pending 2 Accident Investigation				М		ES 2 🗌	NO					
NDIN R. Att	ED	3 Suicide 8 Could not be	28e. PLACE OF I	INJURY — A	t home, farm, s	treet, factor	y, offica			261. LOCATION	N (Street and	Number or Ru	ral Route Number,	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETE	4 Homicide determined		(,						City or 10	WII, SIEID)			
	١٣	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of m	v knowledne	death occurre	d at the time	a deta i	and place o	and due to	a the sever(s)				
国 山内 =	COMPL	(Check only one)  2 MEDICAL EXAMINER											(2) 224	
HOSPI FUNER within		1/1				.,, ср.								
五五百	H	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)						ber)					
P P ≥ ₹	2	NAVY (	17					N.C.	186	2	'	5/2	6145	
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH	( .		DI	1//	111	1.4	4	- 0		
		LIMIN V LT		1/21	Unira	ising 1	0/10	d W.	N	MODIL	MD	209	02	
		31. DATE FILED (Month, Day, Year)	32 REGISTRAR	S SIGNATUR		-								
		MAY 31 1995	Jacon dias	arrec W	artalle									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

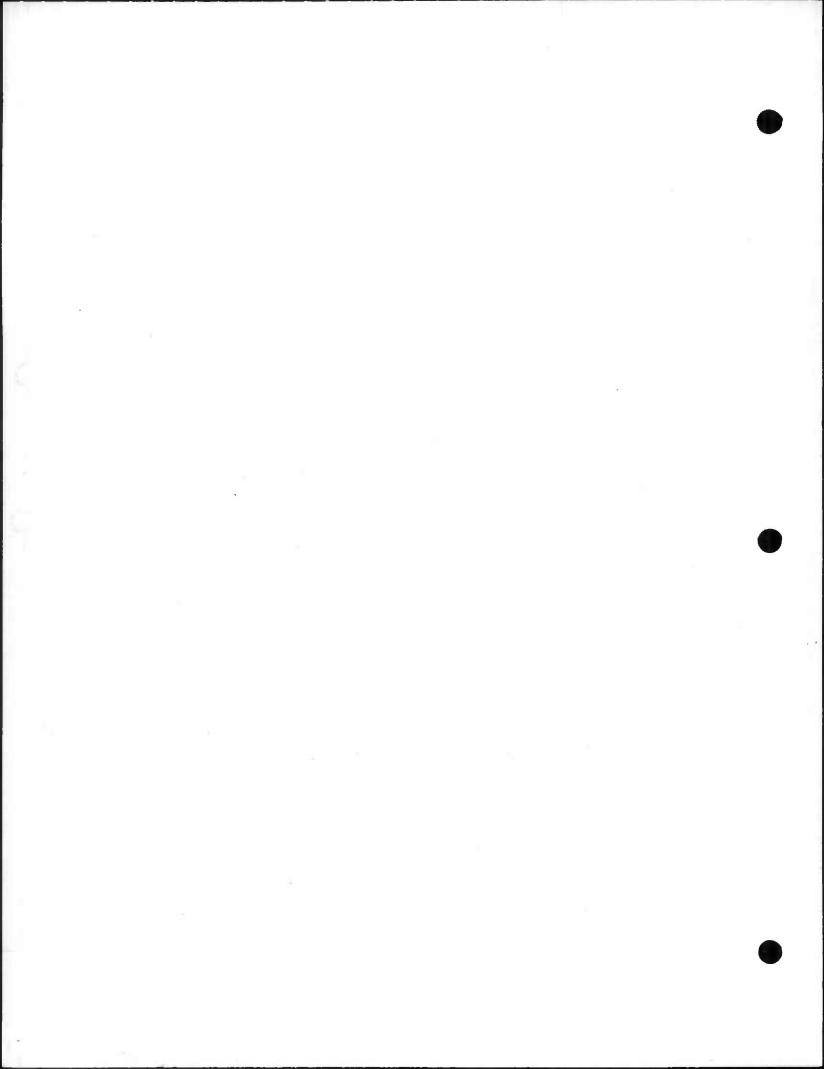
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TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
RAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTA	L HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)		-		- DEATH	2. DATE	ATE OF DEATH			3. TIME OF DEATH		
	Paul L. Roney, S	Sr.				May	H D	1:30	Ам			
			(In yrs. last birthday)	IF UNDER 24 HRS.	May 30, 1995			8. BIRTHPLACE (State or Foreign				
	472-12-3761	1∑ M 2 □ F 7	YRS.	MONTHS DAYS	HOURS MIN.	(Mont	n, Day, Year)	1923	Country	)		
	9e, FACILITY NAME (If not institution, give stre-			9b. CITY, TOWI	OR LOCATION OF D		. 50,		Minnesota TY OF DEATH			
DIRECTOR	2 Surry Court Rockville Montgome											
ñ	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.											
ā	Maryland Mont	tgomery			LIMITS?	NO						
¥	104. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT											
FUNERAL	2 Surry Court 20850									States		
5		12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS D	NIC ORIGIN? (Specify Yea or No- 14, F				RACE — American Indian,			
	1 Never Merried 2 Married	FORCES? 1 X YES			specify Cuban, Mexico ES 2 🔯 NO Specific		orto Rican, etc.) Black, Whi Specify:				hite, atc.	
ВУ	3 Widowed 4 Divorced	World War	П						op com,	White		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION empleted)	16a. DECEDENT'S	USUAL OCCUPA work done during i	TION most of working	168	. KIND OF BUS	SINESS/INDU	STRY			
<u>u</u>		College (1-4 or 5+)	life. Do NOT u	se retired.)	nout of working							
ΜP		5+	Statis	tician			Publ	lic Health				
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First,	Middle, Melden	Surname)				
B	Arthur David Ror	теу			Lulu	Burn	5					
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stree	t end Number or Flural	Route Num	ber, City or Tow	n, State, Zip C	Code)			
	G. Marty Roney		2 Sur	ry Cour	t, Rockvi	11e,	Maryl	and 2	2085	0		
	20e. METHOD OF DISPOSITION 1 Burlel 2 A Cremetion 3 Remove	20b	PLACE AND DATE	OF DISPOSITION (	Nagovine 2,	1 0 CPAT	E 20c. LO	CATION — CI	ty or Tow	n, State		
	4 Donation 5 Other (Specify)	M.	ontgomer	y Crema	June 2, torium, I	inc.	Bet	hesda	, Ma	ryland		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 0 MOOR31 27. NAME AND ADDRESS OF FACILITY											
	Darbara Jo Mch		ollnce	Avent	ie, Kockv	TTTE	, Mary	rand a	2085	mery 0-2805		
	23. PART I. Enter the biseases or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Approximate interval Between Onset and Death  Approximate interval Between Onset and Death  2 years									tween Death		
NOL	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
EHTIFICA	CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):								
핗▮	CAUSE (Disease or Injury thet initiated events				ng csuse given in	Part I.	24a, WAS AN PERFOR	MED?		WERE AUTOPSY FI	AUSE	
핗▮	CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST	contributing to death b	ut not resulting	In the underlyi		_	PERFOR	MED?		MAILABLE PRIOR COMPLETION OF C	AUSE	
핗▮	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions  DID TOBACCO USE CONTRII  25. WAS CASE REFERRED TO MEDICAL	contributing to death b	ut not resulting	In the underly!	UNCERTAI	_	PERFOR	MED?		MAILABLE PRIOR COMPLETION OF C OF DEATH?	AUSE	
핗▮	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	contributing to death b	OF DEATH YE	In the underlyi	UNCERTAI	N 🗆	PERFOR	MED?		MAILABLE PRIOR COMPLETION OF C OF DEATH?	AUSE	
핗▮	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O	DF DEATH YE 26. PLACE OF DEA estient 3 □ DOA	In the underlyi	UNCERTAII	N 🔲	PERFOR	MED?		MAILABLE PRIOR COMPLETION OF C OF DEATH?	AUSE	
Y PHYSICIAN: MEDICAL CERTIFICATION	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  DID TOBACCO USE CONTRII  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	BUTE TO CAUSE O	DF DEATH YE 26. PLACE OF DEA estient 3 □ DOA	In the underlyi	UNCERTAI	N 🔲	PERFOR  1  YES 2	MED?		MAILABLE PRIOR COMPLETION OF C OF DEATH?	AUSE	
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O	P DEATH YE 28. PLACE OF DEA 28b. TIM N.	In the underlyi	UNCERTAI	8  Other	PERFOR  1  YES 2	MED?	RED	MARLABLE PRIOR COMPLETION OF C OF DEATH? 1 YES 2 🔀 I	AUSE	
TED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O  OSPITAL:   Inpetient 2   ER/Outp  (Month, Day, Year)  28e. PLACE OF INJURY 28e. PLACE OF INJURY	P DEATH YE 28. PLACE OF DEA 28b. TIM N.	In the underlyi	UNCERTAI	8  Other	PERFOR  1 YES 2  r (Specify)  CRIBE HOW II	MED?	RED	MARLABLE PRIOR COMPLETION OF C OF DEATH? 1 YES 2 🔀 I	AUSE	
ETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O  OSPITAL: Inpetient 2 EP/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	PF DEATH YE 26. PLACE OF DEA 28b. TIM IN.  — At home, farm,	In the underlying the	UNCERTAII  D)  D)  D)  D)  D)  D)  D)  D)  D)	8 Other 26d. DES	PERFOR  1 YES 2  If (Specify)  CRIBE HOW II  ATION (Street a or Town, State)	MED?  NO  NJURY OCCU  nd Number or	RED Rural Ro	MARLABLE PRIOR COMPLETION OF ( OF DEATH?  I  YES 2 X I	TO AUSE	
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  DID TOBACCO USE CONTRIL  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 Natural 5 Pending Investigation 3 Suicide 1 Notice Security Investigation 3 Suicide 5 Could not be determined	BUTE TO CAUSE O  OSPITAL: Inpetient 2 EP/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	PF DEATH YE 26. PLACE OF DEA 28b. TIM IN.  — At home, farm,	In the underlying the	UNCERTAIL  b)  mme 5 X Residence NJURY AT NORK?  YES 2 NO  ice  te end place, end due death occured at the	8 Other 28d. DES 28f. LOC City to the cau	PERFOR  1 YES 2  If (Specify)  CRIBE HOW II  ATION (Street a or Town, State)	MED?  NO  NJURY OCCU  nd Number or  ner as stated d due to the o	RED  Rural Ro	MARLABLE PRIOR COMPLETION OF C OF DEATH?  I YES 2 2 1 1  ute Number,	TO AUSE	
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O  OSPITAL: Inpetient 2 EP/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	PF DEATH YE 26. PLACE OF DEA 28b. TIM IN.  — At home, farm,	In the underlying the	UNCERTAIL  D)  D)  D)  D)  D)  D)  D)  D)  D)  D	8 Other 26d. DES 26f. LOC City to the case time, date	PERFOR  1 YES 2  F (Specify)  GCRIBE HOW II  ATION (Street a or Town, State)	MED?  NO  NJURY OCCU  nd Number or  ner as stated d due to the c	RED  Rural Ro  cause(e)	MARLABLE PRIOR COMPLETION OF ( OF DEATH?  I VES 2 X I  ute Number,  and menner se s  Month, Day, Year)	TO AUSE	
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  DID TOBACCO USE CONTRIL  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 YES 2 NO  1 YES 2 NO  1 CERTIFIER (Check only and processes) 1 CERTIFIER MEDICAL EXAMINER.	BUTE TO CAUSE O  HOSPITAL: Inpetient 2 = ER/Outp  28e. PLACE OF INJURY (Month, Day, Year)  28e. PLACE of INJURY building, etc. (Spec	DF DEATH YE  28. PLACE OF DEA  28b. TIM  No.  At home, farm,  ledge, death occurr  n end/or investigation	In the underlying the	UNCERTAIL  b)  mme 5 X Residence NJURY AT NORK?  YES 2 NO  ice  te end place, end due death occured at the	8 Other 26d. DES 26f. LOC City to the case time, date	PERFOR  1 YES 2  F (Specify)  GCRIBE HOW II  ATION (Street a or Town, State)	MED?  NO  NJURY OCCU  nd Number or  ner as stated d due to the c	RED  Rural Ro  cause(e)	MARLABLE PRIOR COMPLETION OF C OF DEATH?  I YES 2 2 1 1  ute Number,	TO AUSE	
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury thet Initiated events resulting in deeth) LAST  PART II. Other significent conditions of the co	BUTE TO CAUSE O  HOSPITAL:   Inpetient 2	PF DEATH YE  26. PLACE OF DEA  Petient 3 DOA  28b. TIM IN.  At home, farm, ledge, death occurr in end/or investigation  ATH (ITEM 27) (Type	In the underlying the	UNCERTAIL  D)  D)  D)  D)  D)  D)  D)  D)  D)  D	8 Other 28d. DES	PERFOR  1 YES 2  If (Specify)  SCRIBE HOW II  ATION (Street e or Town, Stete)  INSE(e) end men and place, en	MED?  NO  NJURY OCCU  nd Number or  ner as stated d due to the company of the company occupan	RED  Rural Ro  couse(e)  BIGNED (17 31	MARLABLE PRIOR COMPLETION OF C OF DEATH?  I  YES 2 X I  ute Number,  and menner se s  Month, Day, War)  1 1995	IO atted.	



BALTIMORE, MARYLAND 21215-0020	leath. Page 6 may be retained by the hospital or attending physicia	funeral director, page 5 should be detached for use as the burial-t
18	24 hours after d	filled in by the
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physici:	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-ti

burial-transit permit. Pages 1, 2, 3 should physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

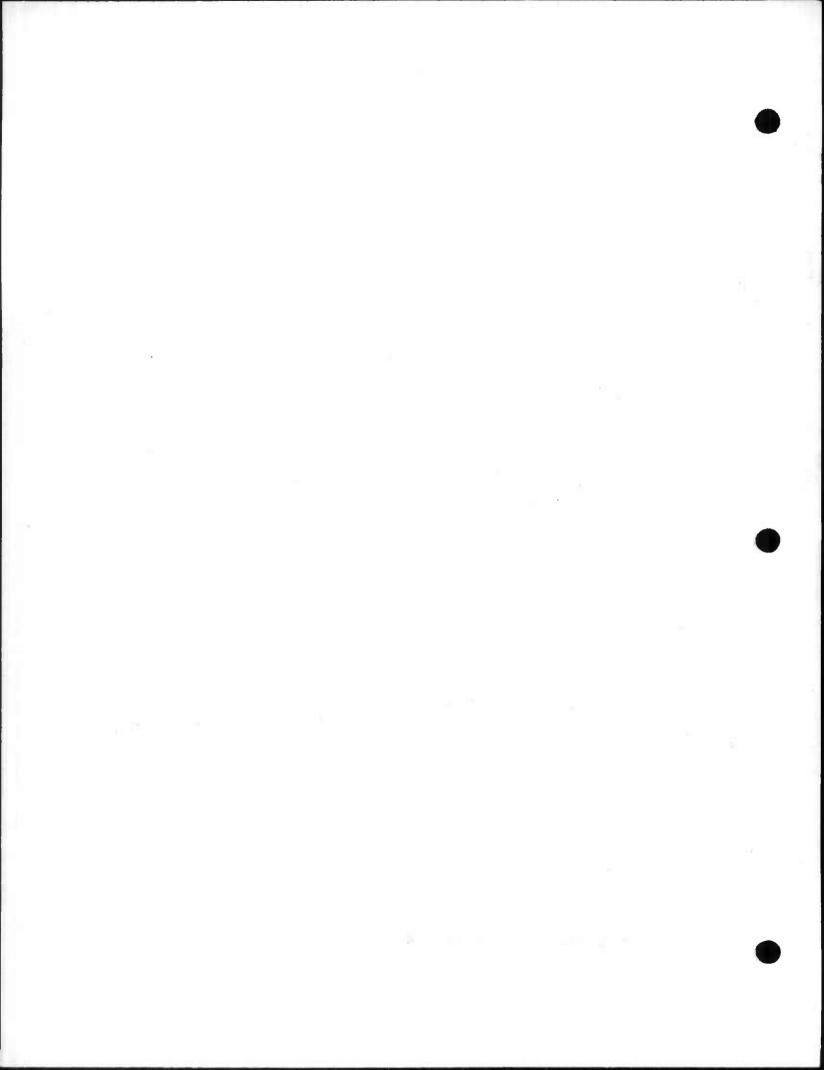
	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF I		MENTAL HYGIENE		
	1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATN		3. TIME OF OEATH
	ALLEN	S.	RI	CKETTS	,	MAY 30	1995	9:30 P M
	4. SOCIAL SECURITY NUMBER	- 100 mm	'In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	Count	NPLACE (State or Foreign
	214-60-4536		3 YRS.				,1952	"Maryland
œ	96. FACILITY NAME (If not institution, give street end number)  96. CTY, TOWN OR LOCATION OF DEATN  96. COUNTY OF DEATN							
DIRECTOR	19600 PEACHTREE ROAD DICKERSON MONTGOME							
REC	10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCA	TION		10d. INSIDE CITY LIMITS?		
		gomery	D	ickers	on			1 X YES 2 ☐ NO
RAI	100. STREET AND NUMBER 19600 Peachtre	o Dood		10	. ZIP COOE		10g. CITIZEN OF	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	III ADMED	1 40 1110 000	20842		U.S.A	
	12 Never Married 2 Married	FORCES? 1 YES	2 (XNO	If yes, ap	ecity Cuban, Maxica	NC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	Blac	E — Americen Indian, k, White, etc.
В	3 Wildowed 4 Divorced	IF TES, GIVE WAR ON DE	AIES	1 TYES	2 NO Specify	e.	Spec	Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S U	SUAL OCCUPATION done during me	ON pst of working	16b. KIND OF BUSI	INESS/INDUSTRY	
빌	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)		71.	01	
Š	17. FATHER'S NAME (First, Middle, Last)	3½ yrs	riectro	onics i	Enginee:		Circu	lts
	Marvin T. Rick	etts				ME (First, Middle, Maiden S	iurname)	
BE	19a, INFORMANT'S NAME (Type/Print)		196, MAILING	ADDRESS (Street a		Route Number, City or Town.	State, Zip Code)	
임	Ann Whisonant	(Mother)	206 W.	interg	reen La	ne, Bruns	swick.	MD 21716
	20a. METHOD OF DISPOSITION 12 Burla! 2 ☐ Cremation 3 ☐ Ramo	ovet from State 20b	PLACE AND DATE OF	OISPOSITION (N	ime of	DATE 20c LOC	ATION City or To	
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	J	erusalei				olesvil	le, MD
	21. SIGNATURE OF PUNEHAL SERVICE LIC	ENSEE	1. /		DEN FIN		7 D 7	
_	Tence K.	Anond	w	ROCK	VILLE,	ERAL HOME MD 20850	), F.A.	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF)					
_ 1	PART ii. Other significant conditions	contributing to death b	ut not reaulting in	the underlying	g cause given in	Part i. 24a. WAS AN A	1000	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA						1/X YES 2		COMPLETION OF CAUSE OF DEATH?
ž	212 222 422 442					_ /		YES 2 NO
A N	DID TOBACCO USE CONTR		F DEATH YES 26. PLACE OF DEATH		UNCERTAIN	10		
띯	EXAMINER? 1 Z YES 2 NO	HOSPITAL:		THER.	e 5X Rasidence			
ξ∥	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TIME	OF 26c. INJ	URY AT	26d, DESCRIBE NOW IN.	JURY OCCURED	
BY	1 Netural 5 Pending 2 Accident Investigation	5/30/95	CIPK	M 1 .	PK?	Subject	-81st	self
ا ۵	3 Sulcida 8 Could not be	26e. RLACE OF INJURY building, etc. (Spec	- At home, farm, atr	eet, factory, offic		26f. LOCATION (Street an City or Yown, State)	d Number or Rural I	Poute Number,
E	-		Home			19600 Pes	effret	140
COMPLE		CIAN: To the best of my knowl						
8		R: On the basis of examination	and/or investigation,	in my opinion, d	eath occured at the	time, data and place, and	dua to the cause(s	a) and manner ee stated.
98	296. SIGN CTURE AND TITLE OF CERTIFUER	when	0		O.C.M.		P MAY	(Month, Day, Year) 31,1995
	TUAREN COU	COMPLETED CAUSE OF DE			ET, BALTI	IMORE, MAR	YLAND 2	21201
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	TURE	221121		, , , , , , , , , , , , , , , , , , , ,		
	JUN 02 1995	Julia Davidson	hardall					

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BALTIMORE, MARYLAND 21215-002	
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JUN 0 6 1995

32. REGISTRAD'S SIGNATURE

		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / I	DEPART RTIFI	TMENT OF H	HEALTH AND	MENT	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEATH	lv.	YEAR	3. TIME OF DEATH
5		LUCII		ROBEI	-			Jur		199		3:40 AM M
		4. SOCIAL SECURITY NUMBER		(in yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Moi	E OF BIRTH th, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
should		242-22-8130  9a. FACILITY NAME (If not institution, give	12		YRS.	Ob CITY TOWN	201201101101101		21,1			h Carolina
60	HO	501 Red Pump Roa			ı		OR LOCATION OF D					
1, 2,	5	RESIDENCE OF DECEDENT				Bel Air			Harford		riora	
Page	DIRECTOR	10e. STATE 10b. COUNT		1	10c. CITY	, TOWN OR LOCA						Od. INSIDE CITY LIMITS?
permit. Pages		Maryland 100. STREET AND NUMBER	Harford			10	Bel Ai	r		10a CITIZ		TYES 2 NO
isi	FUNERAL	501 Red Pump	Road		21014					l logi or ila	USA	NI COONTRIT
020 physician. burial-transit	NO.	11. MARITAL STATUS	12. WAS DECEDENT EVER				ENDENT OF HISPA			or No-	14. RACE -	- American Indian,
5-0020 nding physic	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR								Specify:	White, etc.
215-0020 attending physician. se as the burial-trar		15. DECEDENT'S EDU		16a, DEC	EDENT'S L	USUAL OCCUPATION	DN:	140	b. KIND OF BUS	INESS (IND)	IOTOV	White
2121	ET	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give	o kind of we	ork done during mo	ast of working	1	b. KIND OF BUS	micaa/inu	JOINT	
Ched 1	COMPLETE	11			Home	maker				Home		
YLAND 2. by the hospital of the detached for at once.	CO	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First.	Middle, Melden	Surname)		
RYL ed by	BE	Drury Dixon Gr	eene				Maude			ander	_	
TOKE, MAK e 6 may be retained I ector, page 5 should must be notified	2						and Number or Rural				Code)	
		Glenn T. Robers						DATE 20c. LOCATION — City or Town, State				
		1 N Shirtel 2 Commetton 3 Ren 4 Donation & Other (Specify)	novel from State Col	metery crem	atory or oth	per place)	Gardens	1				
death, Pag thereal direction		21. SIGNATURE OF AUGURNAL SERVICE LI	celulary //	mid	/	22. NAME A	ND ADDRESS OF FA	CILITY				
0- 0		· / MTWally	12-100	MO	150	HOWard	d K. McC Broadwa	omas v St	III Fi	unera Air	L Hor	ne, P.A. 21014
ica at		23. PART L'Enter the diseases, or shock, or heart failure.	complications that ceuse List only one cause on e	d the deal	th. Do no	ot enter the mo	de of dylng, suc	h ea ca	diac or reapi	ratory arre	et,	Approximate
		IMMEDIATE CAUSE (Final	1									Onset and Death
Tately to		disease or condition resulting in death)					707 MATTC					2 44
P 0 1 5	_		DUE TO (OR AS A CONSEQUENCE OF):									
OX 687 be executed sician and con- rior to burial, traumatic en	CERTIFICATION	Sequentially list conditions, If any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):										
BOX ficate be exphysician a ne prior to her traum	CAI	cause, Enter UNDERLYING CAUSE (Disease or Injury										
P.O. B ath certificat tending phy al Hygiene p or other	THE	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEOU	ENCE OF)	:						
	SER	Todaling in county Exci	d									
in the parties of the Diagram of the	AL (	PART II. Other aignificant condition	na contributing to deeth i	out not rea	nulting in	the underlying	g cause given in	Part I.	24a. WAS AN PERFOR			PERE AUTOPSY FINDINGS
s that ned b lifth ar									1 TYES 2		0	VAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
w requires that been signed by it. of Health and shows any	MEDIC									/		YES 2 NO
as t as 23	AR	DID TOBACCO USE CONT	RIBUTE TO CAUSE C				UNCERTAI	ИП				
OF VITA PHYSICIAN: The this certificate ha with the State D rked, or item	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 YOU	HOSPITAL:			OTHER:	4/-					
SICIAL Certiff	PHYS	27. MANNER OF DEATH	1 Inpetient 2 ER/Out		28b. TIME	OF 28c, INJ	• 5 KRasidence		SCRIBE HOW IT	LJURY OCC	IRED	
NG PHYS frer this c eath with marked,	ВУ Р	1 Neturel 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJU		RK7 FES 2 NO					
ATTENDING F ECTOR: After s after death		3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spe	/ — At home	e, farm, str	reat, factory, office	•	26f. LO	CATION (Street a or Town, State)	nd Number o	r Rural Rou	te Number,
DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETE	4 Homicide determined										
	APL	29a. CERTIFIER (Check only one)	ICIAN: To the best of my know	rledge, dsati	h occurred	at the time, data	and place, and due	to the ca	use(s) and man	ner as state	d.	
HOSPITAL FUNERAL WITHIN 72	COMPL	2 MEDICAL EXAMINE	ER: On the basis of examination	n and/or inv	restigation,	, in my opinion, d	eath occured at the	time, dat	and place, and	dua to the	cause(s) s	nd manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE (	296. SIGNATURE AND TITLE OF CERTIFIE	R				29c, LICENSE NUI	MBER 7 2		29d. DATE	SIGNED (A	brith, Day, Year)
5 5 3 A	10	30 NAME AND ADDRESS OF DEPOSIT	O COMPLETED ONLY	Awat arms	<b></b>		12271	30		P 6	15)	91-
1		30. NAME AND ADDRESS OF PERSON WH	W. MO.	69	27) (Type, F	(MAA	10.57		11	. 50	40	2/204
- 1		3-7-1 00-7-	, , 63	01	/	17/			170	4.	10	4/207



מער וואסטר, ואסט וראוור	ours after death. Page 6 may be retained by the hosp	d in by the funeral director, page 5 should be detache or removal.	medical examiner must be notified at once.	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

N. A. S. (31. DATE FILED (Month, Day, Year)

JUN U 2 1995

	1 - FOR 1 - STATE REGISTRAR	STATE OF MARYL		DEPARTMEN RTIFICAT			MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)  RV TH	JUNE R	LIL	L	2 01	DEATH	2. DATE	OF DEATH		YEAR 3.	TIME OF DEAT	ρ "
	4. SOCIAL SECURITY NUMBER 215-26-1787	1 🗆 M 2 🔀 F	(In yrs. lest i	YRS. IF UNDS	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH		Country)	ACE (State or For	reign
TOR	9a. FACILITY NAME (If not institution, give s  Carroll County  RESIDENCE OF DECEDENT		ospi			minste				roll		
DIRECTOR	10a. STATE 10b. COUNTY	arroll		10c CITY, TOWN West							d. INSIDE CITY LIMITS?	
FUNERAL	532 Morelock				10f	21158			U.S		T COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR DO	2 NO	ED 13	If yes, spi	ENDENT OF HISPAF scify Cuban, Maxica 2 XNO Specifi	an, Puerlo	N? (Specify Yes Rican, etc.)	or No—	Black, V	American India Mita, stc. White	n,
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give	EDENT'S USUAL (  o kind of work done  o NOT use retired.)	during mo:	at of working	1	Conr		TIO:	& F1	vnn
ш	17. FATHER'S NAME (First, Middle, Lest) Harry F. Greer	sr.	Rec	AT DOC	acc	18. MOTHER'S NA	ME (First,		Surname)	1 pc1	0 11	y 1111
TO B	19a. INFORMANT'S NAME (Type/Print)  Mervin L. Rill		196.	MAILINO ADDRES	eloc	nd Number or Rural i	Route Num	ber, City or Tow Iouse	n, Statu, Zip C Rd •	West	minst	er,
	20a. METHOD OF DISPOSITION  1 (XBurial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	oval from State cem	netery, crema	DDATEOFDISPO atory or other place ninste:	r Ce	metery	6/:	2 Wes	cation – ci tmins	ster	, Md.	
	· Namy t	Fletche	1	2	354	East Ma	in a	Stree	t,West	min	AL HOM	Md.
	23. PART I. Enter the diseases, or called the second shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	AWTE	ech line.	YOCA		IAL					Approxima interval Be Onset and	tween
TION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQU	ENCE OF):								
PHYSICIAN: MEDICAL CI	PART II. Other eignificant condition	e contributing to death b	ut not rea		ndarlying	causa given in	Part I.	24s. WAS AN PERFOR 1 YES 2	MED?	AM CO OF	RE AUTOPSY FIN ALABLE PRIOR T MPLETION OF CA DEATH?	O NUSE
IAN: N	DID TOBACCO USE CONTE			OF DEATH Check	NO 🗆	UNCERTAIN	N 🗆				YES 2 N	0
HYSIC	EXAMINER?  1   YES   NO  27. MANNER OF CEATH	HOSPITAL: 1 npetient 2 ER/Outp 28a. OATE OF INJURY		28b. TIME OF		5 Residence		r (Specify)	JURY OCCU	RED		
B	Netural 5 Pending Investigation 3 Suicide 8 Could not be	(Month, Day, Year)  28s. PLACE OF INJURY building, stc. (Spec	— At home	M	1 🗌 Y		28t. LOC	ATION (Street a			number,	
COMPLETED		CIAN: To the best of my knowl	ledge, death				to the cau	use(a) and men				-
H	290 OTGNATORE AND TITLE OF CERTIFIER	3: On the basis of examinetion	·	emigation, in my	opinion, de	29c. LICENSE NUN		and place, an			orth, Day, Year)	ited.
2	30- NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIFE OF DE	AT11 47504 6	TO (Toron Color)				-		<u> </u>	15	

HO COMPLETEO CAUSE OF DEATH (ITEM 27) (Typo, Print)

A 2. REGISTRAR'S SIGNATURE

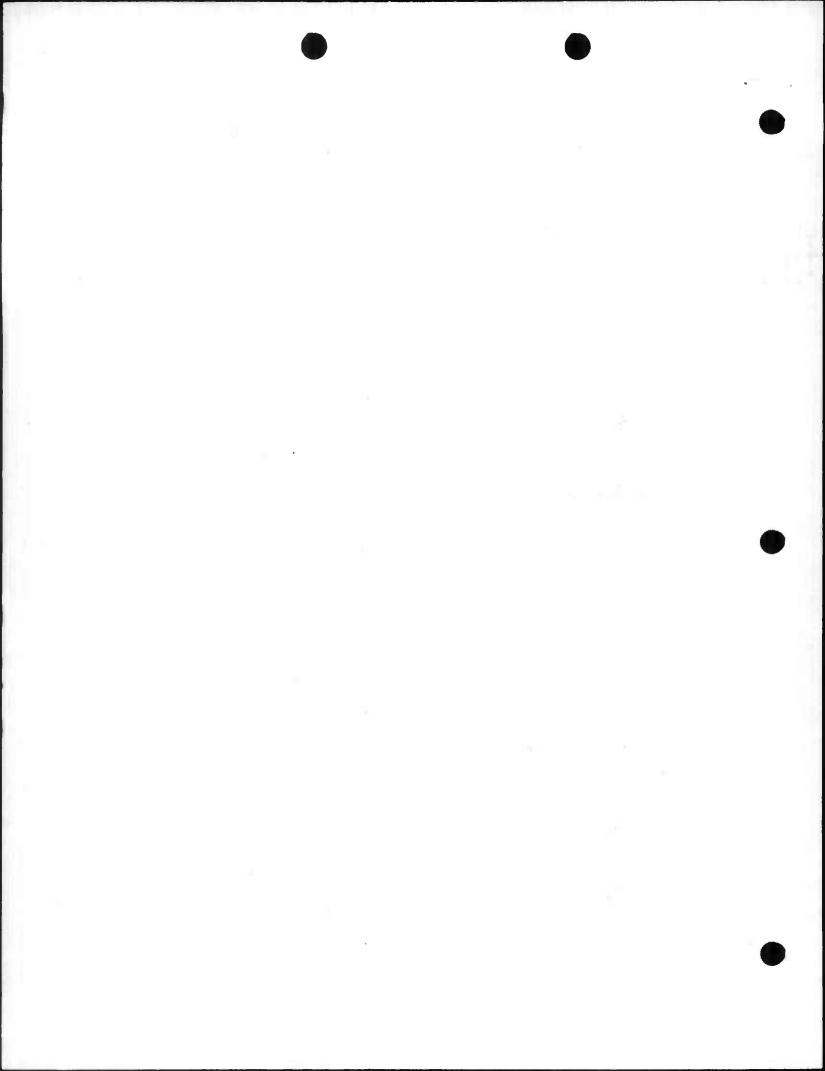
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A WELLOW MANUAL

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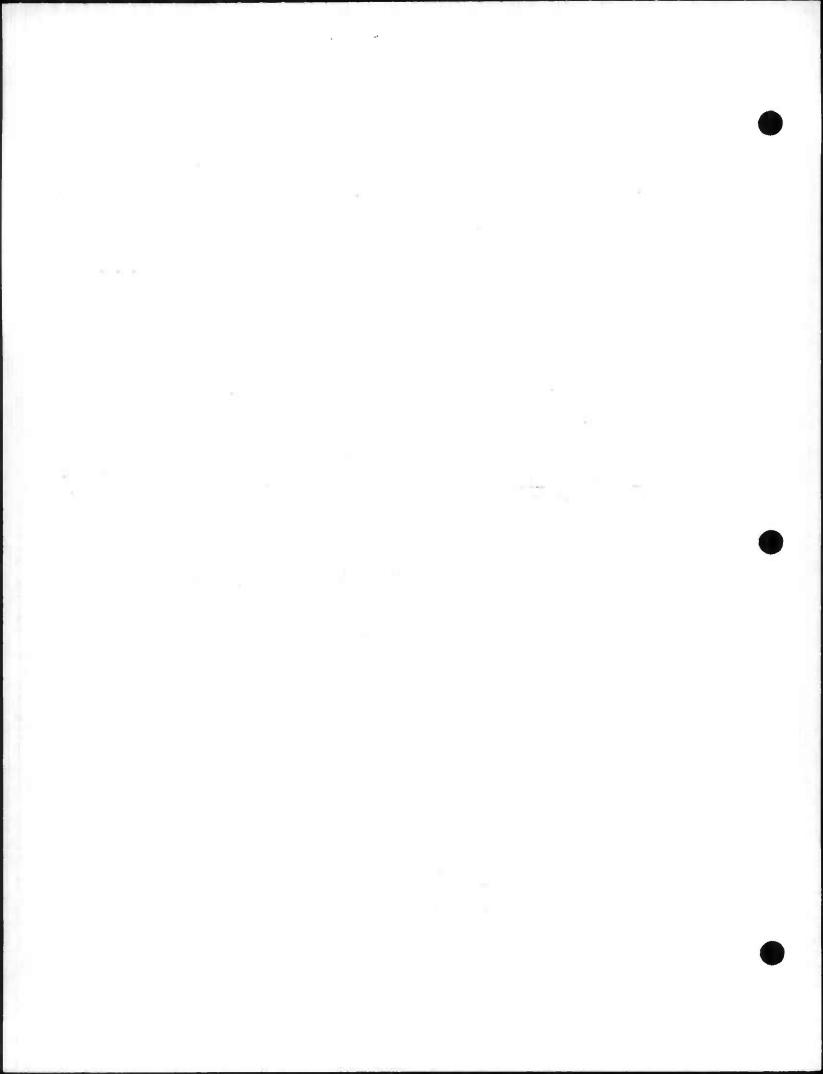
1. DECEDENT'S NAME (First, Middle, Last) Lea Roger Patricia 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 483-46-5898 HOURS 1 M 2 X F 55 YRS. permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OFATH DIRECTOR Ft. Washington Hospital Ft. Washington RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Clinton FUNERAL 10e. STREET AND NUMBER 11305 Colorado Street funeral director, page 5 should be detached for use as the burial-transit 20735 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 140 IF YES, GIVE WAR OR DATES **BALTIMORE, MARYLAND 21215-0020** 1 X Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. GECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 12th Matmatical Statsitician once. 17. FATHER'S NAME (First, Middle, Last) Lawrence L. Rogers BE notified 19a. INFORMANT'S NAME (Type/Print) 2 Lawrence L. Rogers uted within ZA hours after death. Page 6 may be t completely filled in by the funeral director, page 5 fal. cremation, or removal. 9 20s, METHOD OF DISPOSITION
1 X Burial 2 Cramation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Greenwood Cemetery 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finsi the disesse or condition resulting in death) traumatic event, requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CO n and com to burtal. CERTIFICATION Sequentially list conditions, attending physician a ental Hygiene prior to if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disesse or Injury other OUE TO (OR AS A CONSEQUENCE OF that initiated events reaulting in death) LAST 6 the atten Mental PART II. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL and t ЭШУ signed Health a t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: has by Dept. JAM. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The tem certificate h HOSPITAL OTHER: OR ATTENDING PHYSICIAN: 1 TES 2 TONO **©** Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, this with 1XXNatural 1 YES 2 NO ΒY After 2 Accident
3 Suicide 28s. PLACE OF INJURY -- At home, lerm, street, lectory, office building, etc. (Specify) DIRECTOR; A hours after d liem 28 is 90 COMPLETED 8 Could not be 4 Homicide detarmined 1XXCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. TO THE HOSPITAL.
TO THE FUNERAL IS
BE filed within 72 h
IMPORTANT: If II HOSPITAL. 2 MEDICAL EXAMINER: On the beels 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE m) 9

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR

CERTIFICATE OF DEATH 2. DATE OF DEATH 3. TIME OF DEATH June 2,1995 12:35 P 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
April 9,1940 Iowa 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY 1 YES 2 XNO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. Caucasian 16b. KIND OF BUSINESS/INDUSTRY Bureau of Census 18. MOTHER'S NAME (First, Middle, Maiden Surname) Inez F. Crees 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Orange Street Muscatine IA 52761 20c. LOCATION — City or Town, State Muscatine Iowa 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md Interval Batwe Onset and Death 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number City or Town, State) of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNEO (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas P. Gage 10905 Fort Washington Rd, #405, Fort Washington, MD 32. REGISTRAR'S SIGNATURE
Talia d'Aurolion Randell



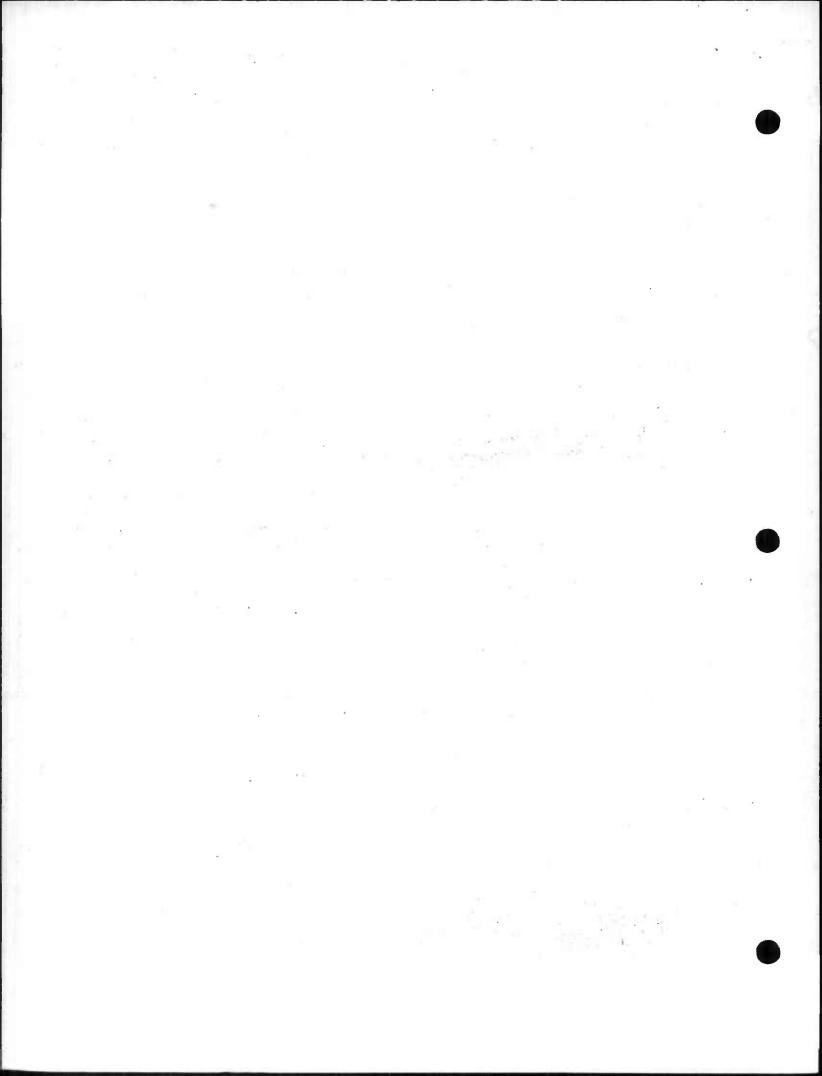
BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physicia
BAL	fter deat
	hours at
50	within
3OX 68760	te be executed
0	Pe
00	9

DIVISION OF VITAL RECORDS, P.O. BOX

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT. If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.  TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION		
The FUNERAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.  TO BE COMPLETED BY FUNERAL DIRECTOR	THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after	or death. Page 6 may be retained by the hospital or attending physician.
event, the medical examiner must be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by it be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or remore	he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rail.
	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medica	examiner must be notified at once.
	) BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG NO

1. DECEDENT'S NAME (First, Middle, La			CERTIFI	CATE	: OF	DEATH		EG. NO.				
Flamence E							2. DATE OF MONTH	DA	IA.	YEAR	3. TIME OF DEAT	
Florence E.  4. SOCIAL SECURITY NUMBER	Keam 5. SEX						June			95	2:20	Р
209-05-4204	1 🗆 M 2 💢 F	6. AGE (In yrs. 97		IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, De 09/	77/9	7	Country	PLACE (Stote or Fo	reign
9e. FACILITY NAME (If not institution, gi		_				R LOCATION OF D			9c. COUNT	Y OF DE	ATN	
Goodwill Men		ome		G	ran	tsvill	e		Ga	rre	tt	
MD G	arrett		10c. CITY	Gra		ville					10d. INSIDE CITY LIMITS? t YES 2	
10%. STREET AND NUMBER					101.	ZIP CODE 2153	6		10g. CITIZ	US.	HAT COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		TYER IN U.S. ARMED  13. WAS DECENDENT OF NISPANIC  14 yes, specify Cuban, Mexicen,  1 YES 2 NO Specify:				HC ORIGIN? (Specify Yee or No.— 14. RAC in, Puerto Rican, etc.)				ACE - American Indian, ack, White, etc.		
15. DECEDENT'S E (Specify only highest gr	ade completed)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				t6b. Kif	D OF BUS	SINESS/INDU			
Elementary/Secondary (0-12)	College (1-4 or 5	*)	Hou	sew:	ife		_ i					
17. FATNER'S NAME (First, Middle, Last) Frank Mitc	hell					16. MOTHER'S NA	AME (First, Midd					
19e. INFORMANT'S NAME (Type/Print)			19b. MAJLING	ADDRESS	(Street e					Cordel		
Donald Cra	mer	- 1	19b. MAILING ADDRESS (Street end Number or Rural Ros								, MD 2	210
20e. METHOD OF DISPOSITION		20b. PLA	CE AND DATE O	F DISPOSI					CATION — CI	_		
X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	amoval from State	cemeter	crematory or oth	er place)	ter	v	1	i .			le, PA	
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. !	NAME AN	O ADDRESS OF F	CILITY					
> may	90/	Qu	/			ert Fu						
23. PART I. Enter the disesses, o	or complications the	st caused the	death. Do no			. Box					PA 154	
shock, or heart fellu	re. List only one cer	use on each i	ilne.	01101		se or aying, sac	on as cardisc	or respi	atory sire	mt,	interval B	twee
iMMEDIATE CAUSE (Final disease or condition	9 1		u. n		7-	4.5	Inil.				Onset and	Deat
resulting in death)	S. DUE TO	(OR AS A CON	ACONSEQUENCE OF):  A CONSEQUENCE OF):  A CONSEQUENCE OF):				y Jun				14	Lyn
	- Cd	man	LTA	(	7.7/						276	1.
Sequentially list conditions,	b. OUE TO	(OR AS A CON	SEQUENCE OF	1	J. J.						1	-
if any, leading to immediate cause. Enter UNDERLYING	C.	(OR AS A COM	SECUENCE OF	):								
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	cDUE TO	(0., 10 1 00.										
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c. DUE TO	(611 716 71 6011									_i	
It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	d		ot resulting is	the un	derlying	ceuse alven in	Port i	WAC AN	ALITOROV	Lais	1	
If any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disesse or Injury that initiated events resulting in death) LAST	d.		ot resulting in	the un	derlying	ceuse given in	Part i. 24	. WAS AN			WERE AUTOPSY FI AVAILABLE PRIOR	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit	d	deeth but no	ot resulting in	the un	derlying	ceuse given in			MED?			TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condit	lons contributing to	deeth but no	m				t:	PERFOR	MED?		AVAILABLE PRIOR COMPLETION OF C	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit	d.  lone contributing to  from  type 4:3	deeth but no	m		H Y	ES   NO		PERFOR	MED?		AVAILABLE PRIOR COMPLETION OF C OF DEATH?	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	Ions contributing to	deeth but no	USE OF	DEAT	H YI	ES NO	neck only one)	PERFOR	MED?		AVAILABLE PRIOR COMPLETION OF C OF DEATH?	TO AUSE
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	d. lone contributing to	TO CA	USE OF	OTHER 4) H-Nura	H YI 26, PL 1: Ing Nome	ES NC  ACE OF DEATH (C/	neck only one)	PERFOR	MED?		AVAILABLE PRIOR COMPLETION OF C OF DEATH?	TO AUSE
If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MO  27. MANNER OF DEATN  1 Netural 5 Pending	Ions contributing to	TO CA	USE OF	OTHER 4) H-Nura	H YI 26, PL 8: Iling Nome 26c. INJI	ES NC  ACE OF DEATN (CI  5 S Residence  JRY AT  RK?	t (  neck only one)  6 Other (Sp	PERFOR	MED?		AVAILABLE PRIOR COMPLETION OF C OF DEATH?	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MAO  27. MANNER OF DEATN	Ions contributing to  CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26s. OATE OF	TO CA	USE OF	OTHER 4 H-Mura OF JRY	26, PL R: ling Norma 26c. INJU WOI	ES NC  ACE OF DEATN (C/  5 S Residence  JRY AT  RK7  ES 2 NO	heck only one)  6 Other (Sc  26d. DESCRI  281. LOCATIO	PERFOR  YES 2  Becity)  BE NOW II	MED?  NO	PRED	AMAILABLE PRIOR COMPLETION OF C OF DEATH?  1 YES 2   I	TO
PART II. Other significant conditions in the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions in the condition of the conditions in the cause of the caus	CONTRIBUTE  HOSPITAL:    Inpetient 2    26e. PLACE Coulding,	ETO CA  ER/Outpstlant FINJURY Ley, Year)  OF INJURY — All etc. (Specify)	USE OF  3 DOA  28b. Time INJU	OTHER 4 )HAUTE	26. PL 1: sing Norm 26c. INJ WOI 1 Y Ory, office	ES NC ACE OF DEATH (C) 5 S Residence JRY AT RK7 ES 2 NO	heck only one)  6 Other (Sp. 26d. DESCRI	PERFOR  YES 2  DECITY)  BE NOW III  N (Street even, State)	MED?  NO  NJURY OCCU	PRED r Rural Ro	AMAILABLE PRIOR COMPLETION OF C OF DEATH?  1 YES 2   I	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES SOMO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation of Could not determined  29e. CERTIFIER (Check only)	Ions contributing to  CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26s. OATE OF	TO CA  ER/Outpstlant FINJURY Ley, Year)  OF INJURY — All etc. (Specify)	USE OF  3 DOA  26b. TIME INJU	OTHER  OTHER  A) N-Mura  OF  INV  M  Irrest, factor	26, PL 1: 26, PL 26: NJ WOI 1  Y Ory, office	ES NC  ACE OF DEATH (CI  5 Residence  7RY  RR7  ES 2 NO  end place, end due	6 Other (Sp. 26d. DESCRI	PERFOR  YES 2  Weclfy)  BE NOW III  N (Street e wm, State)	MEO?  NO  NO  NUMBER OCCU	PRED r Rural Ro	AMAILABLE PRIOR COMPLETION OF	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation of Could not determined  29e. CERTIFIER (Check only)	Ions contributing to  CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26a. DATE OF Month, D  26b. PLACE C building,  YSICIAN: To the best of a	TO CA  ER/Outpstlant FINJURY Ley, Year)  OF INJURY — All etc. (Specify)	USE OF  3 DOA  26b. TIME INJU	OTHER  OTHER  A) N-Mura  OF  INV  M  Irrest, factor	26, PL 1: 26, PL 26: NJ WOI 1  Y Ory, office	ES NC  ACE OF DEATH (CI  5 Residence  7RY  RR7  ES 2 NO  end place, end due	neck only one)  6 Other (Sc 26d. DESCRI  261. LOCATIC City or R  to the cause(a	PERFOR  YES 2  Weclfy)  BE NOW III  N (Street e wm, State)	MEO?  NO  NJURY OCCU  Ind Number or  Iner as stated did due to the	IRED  r Rural Ro	AMAILABLE PRIOR COMPLETION OF	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	Ions contributing to  CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26a. DATE OF Month, D  26b. PLACE C building,  YSICIAN: To the best of a	TO CA  ER/Outpstlant FINJURY Ley, Year)  OF INJURY — All etc. (Specify)	USE OF  3 DOA  26b. TIME INJU	OTHER  OTHER  A) N-Mura  OF  INV  M  Irrest, factor	26, PL 1: 26, PL 26: NJ WOI 1  Y Ory, office	ES NC  ACE OF DEATN (CI  2 5 Residence  JRY AT  RK7  ES 2 NO  end place, end due  esth occured at the	neck only one)  6 Other (Sc 26d. DESCRI  261. LOCATIC City or R  to the cause(a	PERFOR  YES 2  Weclfy)  BE NOW III  N (Street e wm, State)	MEO?  NO  NJURY OCCU  Ind Number or  Iner as stated did due to the	IRED  r Rural Ro	AMAILABLE PRIOR COMPLETION OF	TO
If any, leading to immediate cause. Enter UNDERLYING CAUSE. Disease or injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MID  27. MANNER OF DEATN  1 Westural 5 Pending Investigation of Could not independent of Could not in Check only one)  2 MEDICAL EXAMINERY  1 CERTIFYING PN One)  2 MEDICAL EXAMINERY  2 MEDICAL EXAMINERY  1 MEDICAL EXAMINERY  2 MEDICAL EXAMINERY  2 MEDICAL EXAMINERY  1 MEDICAL EXAMINERY  2 MEDICAL EXAMIN	CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26a. OATE OF (Month, E)  25b. PLACE Of building,  VSICIAN: To the best of INER: On the best of e	ER/Outpstland FINJURY — All etc. (Specify)  I my knowledge, examination end.	USE OF  29b. TiME INJU t home, farm, st	OTHER 4 H-Mura 6 OF IRV M Irreet, factor	26, PL 1: 26, PL 26: NJ WOI 1  Y Ory, office	ES NC  ACE OF DEATN (CI  2 5 Residence  JRY AT  RK7  ES 2 NO  end place, end due  esth occured at the	neck only one)  6 Other (Sc 26d. DESCRI  261. LOCATIC City or R  to the cause(a	PERFOR  YES 2  Weclfy)  BE NOW III  N (Street e wm, State)	MEO?  NO  NJURY OCCU  Ind Number or  Iner as stated did due to the	IRED  r Rural Ro	AMAILABLE PRIOR COMPLETION OF	TO AUSE
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condit  DID TOBACCO USE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 MO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation 29. Certifier 1 Certifier determined  29e. CERTIFIER 1 CERTIFYING PN (Check only one) 2 MEDICAL EXAMINER)  29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON	CONTRIBUTE  HOSPITAL: 1   Inpetient 2   26a. OATE OF (Month, E)  25b. PLACE Of building,  VSICIAN: To the best of INER: On the best of e	ER/Outpetland  ER/Outpetland  FINJURY — All  etc. (Specify)  I my knowledge.  xamination end.	USE OF  3 DOA  26b. TIME INJU. t home, farm, st  death occurred for investigation	OTHER 4 Manuary M Irrest, factor d at the til i, in my or	26, PL 1: gling Norm 25c, INJ WOO 1 Y Orry, officer me, date	ES NC  ACE OF DEATN (CI  5 S Residence  7 AT  RK7  ES 2 NO  end place, end due  path occured at the  29c. LICENSE NU	beck only one)  6 Other (Sp. 26d. DESCRI	PERFOR  YES 2  Pecify)  BE NOW II  N (Street e wwn, State)	MEO?  NO  NJURY OCCU  Ind Number of the test stated didue to the test s	IRED  r Rural Ro	AMAILABLE PRIOR COMPLETION OF	TO AUSE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/13/95 t.t FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	),			
- 7	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			3. TIME OF DEA	TH
- 20	DAVON L.	ROBERTS					0. 19	YEAR	0800	<b>λ</b> Μ
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			LACE (State or F	oreian
1	213-86-1391 9e. FACILITY NAME (If not Institution, give st	1-X-X M 2 □ F	24 YRS.	MONTHS DAYS	HOURS MIN.	JULY 2 19	70	MARY	LAND	
BO	ANNE ARUNDEL G.		SPITAL	ANNAP	OLIS	EATH		TY OF DE	RUNDEL	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	*	10c, CIT	Y, TOWN OR LOCA	TION				10d, INSIDE CIT	
	MARYLAND ANNE	AN	NAPOLIS					LIMITS?		
FUNERAL	1900 C COPELAND S	TREET		100	21401	10g. CITIZEN OF V			AT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 Y IF YES, GIVE WAR OF	ES 2 NO	If yes, sp	ENDENT OF HISPAL ecify Cuban, Mexico 2 NO Specifi	NIC ORIGIN? (Specify Yes or No— 14. RACE - an, Puerto Rican, etc.)			American Indi White, etc.	lan,
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPATI	ON set of working	16b. KIND OF BU	SINESS/INDU		OK	
COMPLETED	Elementary/Secondary (0-12) 11th	College (1-4 or 5+)	LABORE	se retired.)	at or worning	SELF I	EMPT.OY	FD		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		עם		
BE C	CLINTON ROBERTS					JONES				
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox				
	DIANE JONES					NNAPOLIS,		_		
	20s. METHOD OF DISPOSITION  1) Buriel 2 Cremetton 3 Ramo 4 Donation 5 Other (Specify)	oval from State	206. PLACE AND DATE ( COMPLETY, COMPAND OF O CHEWS CHU	of disposition (Ma ther place) RCH CEME		OATE 20c. LO	ENSVIL			
	21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AND ADDRESS OF FAC				,		
	Harry			821 W	EST ST.	ANNAPOLIS,	MD.	2140	1	
	23. PART I. Enter the diseases, or c shock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	ACUTE NAR(	n aach lina.  COTIC AND PHI	ENCYCLIDIN			iratory arre	at,	Approxim interval B Onset and	etween
CERTIFICATION	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury									
ERTE	that Initiated events resulting in death) LAST d.									
	PART II. Other algnificent conditions	a contributing to deat	h but not reculting i	In the underlyin	g ceuse given in				VERE AUTOPSY F	
MEDICAL						PERFO		C	MAILABLE PRIOR COMPLETION OF ( OF DEATH?	
Z	DID TOP ACCOUNTS	UDITE TO ALLIES						1	YES 2	NO
A N	DID TOBACCO USE CONTR	GIBUTE TO CAUSE			UNCERTAI	N L		$\perp$		
PHYSICIAN:	EXAMINER? XIXYES 2 \( \square\) NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:	- 0.600-7	CHIES WILL				
Ä	27. MANNER OF DEATH	28a. DATE OF INJUS				6 Other (Specify) 28d. OESCRIBE HOW	NJURY OCCI	IREO		
ВУР	1 Natural 5 Pending 2 Accident Investigation	FOUND 5-10			AK?	UNKNOWN		THEO		
	3 Suicide 8 CCould not be determined	28e. PLACE OF INJU building, etc. (S		IN AUTO		281, LOCATION (Street City or Town, State) ANNE ARUNDE	2100 B	Rural Rou	te Number ERRYMAN	CT.
۳	29a, CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my kr						_		
COMPLETED	(Check only one)  2 DMEDICAL EXAMINER								and manner as a	tated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	// /// .			29c. LICENSE NUI				Aonth, Day, Year)	
2	30. NAME AND AODRESS OF PERSON WAS	COMPLETED CAUSE OF		Print)	O.C.M	L.E	M.F	AY I	1,1995	)
	TO THE POST OF THE PARTY OF THE PARTY.				t, Balt	imore, M	aryla	and	21201	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI			-					
7	MAY 1 6 1995	Laucher Reso	lath							

<b>BALTIMORE, MARYLAND 21215-0020</b>	after death. Page 6 may be retained by the hospital or attending physici
LA	the l
MARY	etained by
шî	De l
S	5 may
M	Page (
ALT	death.
00	s after
	OURS
90	d within 24 h
( 68760	executed

	_	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	ITMENT OF H	EALTH AND DEATH	MENTAL HYGIEN		
10	)	1. DECEDENT'S NAME (First, Middle, Last)  ANNA Mal	rgaretha		mond		2. DATE OF DEATH DO SUNE	AY 1993	3. TIME OF DEATH
3		4. SOCIAL SECURITY NUMBER 213-38-7351	1 🗆 M 2 💢 F	(In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Month, Day, Year) Dec. 19,	Co	RTNPLACE (State or Foreign outly)
1, 2, 3 should	TOR	90. FACILITY NAME (If not inetitution, give Fallston General RESIDENCE OF DECEDENT			96. CITY, TOWN C		Harford		
permit. Pages	DIRECTOR		v Harford	10c. CIT	y, town on locat Aberdee				10d. INSIDE CITY LIMITS? 1 YES 2 NO
120	NERAL	100. STREET AND NUMBER 1007 S. Stepney 11. MARITAL STATUS				21001		US	
	BY FUN	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, OIVE WAR OR D	2 NO	If yes, spe		en, Puerto Rican, etc.)		IACE — American Indien, Heck, White, atc. Specify: White
27	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of a	· ·	en St of working	16b. KIND OF BU		Y
2 8 8	E COMPL	17. FATNER'S NAME (First, Middle, Last)	hrista	Bookke	eper	10. MOTNER'S NA	Mobile Me (First, Middle, Melden (nmn) Pau	,	Park
- 2 8	TO B	19a. INFORMANT'S NAME (Type/Print) Otis R. Redmond				nd Number or Rural i	Route Number, City or Tow Aberdeen,	n, State, Zip Code,	
e 6 may rector, pa		20e. METHOD OF DISPOSITION  1X Burlel 2 Cremetton 3 Rem  4 Donetton 6 Other (Specify)	noval from State cen	b. PLACE AND DATE (	of disposition (Nei ther place) Memorial	Gardens	0ATE 20c, LO	CATION — City o	r Town, State
equires that the death certificate be executed within 24 hours after death. Pen signed by the attending physician and completely filled in by the funeral of Health and Mental Hygiene prior to burial, cremation, or removal.		* Styshin	a. Aduen	b	Howard 1317 (	Cokesbur	omas III F v Rd., Abi	nadon.	Home, P.A. Md. 21009
		IMMEDIATE CAUSE (Final	a. MUHIO/E	ech iine.		de of dying, euc	h ea cardiac or reapi	ratory arreat,	Approximate interval Between Onset and Death
	ERTIFICATION	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с.	A CONSEQUENCE OF					
	MEDICA	PART II. Other eignificent condition  SEPSIS  HYPER THY ROY  DID TOBACCO USE CONT	dism				PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
at the state of th	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 PHO	HOSPITAL: 1 XInpetiant 2 - ER/Outs	26. PLACE OF DEAT	N (Check only one) OTHER:		8 Other (Specify)		
子語書	Β¥	27. MANNER OF DEATH  1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1 Y	RK? ES 2 NO	26d. DESCRIBE NOW II		
OR ATTENDING DIRECTOR: After hours after death		3 Suicide 8 Could not be determined  29a. CERTIFIER 1 SETTIEVING PLAYER	building, etc. (Spec	city)			28f. LOCATION (Street a City or Town, State)		ai rioute Number,
388	2		ICIAN: To the best of my know R: On the besis of examination			eath occured at the	time, date and place, an	d due to the caus	
TO THE HOSPI TO THE FUNEF De filed within	TO BE	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print	103/7	75		E 6, 1995

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AN P. Edwards 2/2 St Ain R

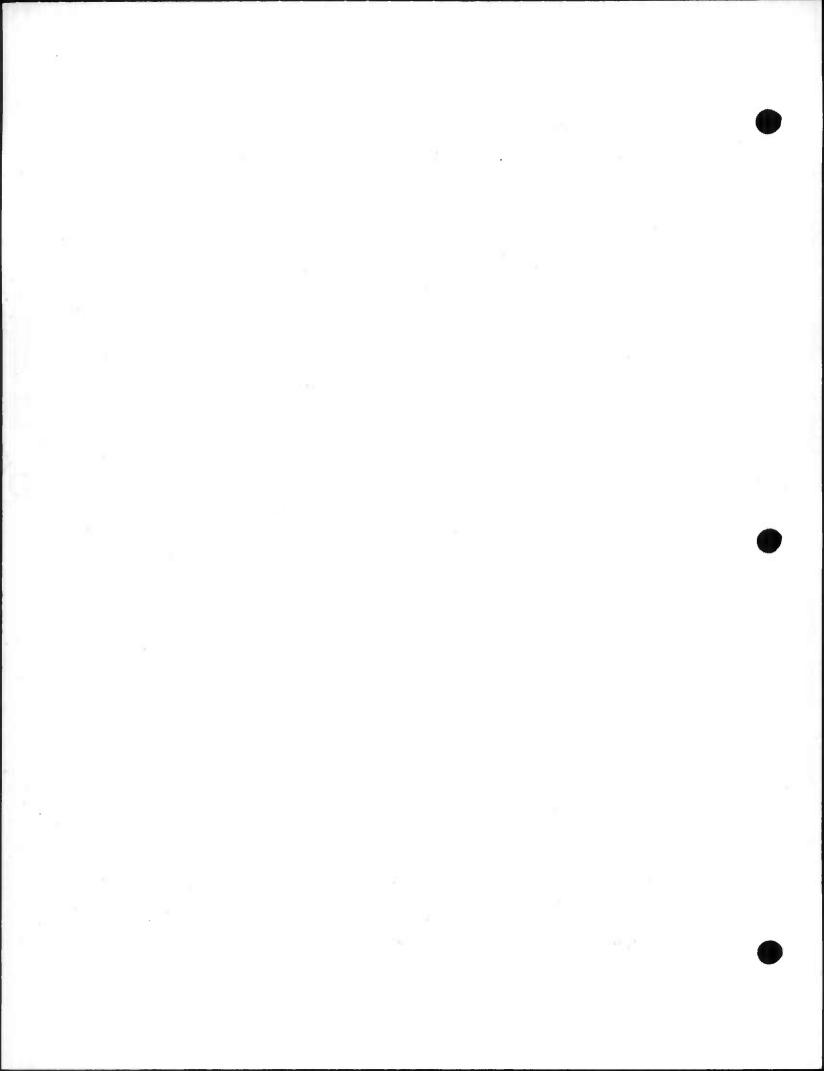
FILED (Month, Day, Year)

32, REGISTRAR'S SIGNATURE

JUN 0 8 1995

Falsa Mauthan-Radal

FAllston Md 21047



1 - STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR		CERTI	-ICATE (	OF DEATH	REG.	NO.			
	1. DECEDENT'S NAME (First, Middle, Least)	Er Riggs	c			2. DATE OF DEATH	DAY	YEAR	E OF DEATH	
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLACE	State or Foreign	
	723-18-7262	1 X M 2 🗆 F	69 yrs.	MONTHS DA	YS HOURS MIN.	1 -1 - 2 2	8	Mary 1	and	
	90. FACILITY NAME (If not institution, give Union Hospital			9b. CITY, TO	WN OR LOCATION OF D	EATH		TY OF DEATH		
	RESIDENCE OF DECEDENT	L			Elkton		C	ecil		
	10a, STATE 10b, COUNT		10c. CI	TY, TOWN OR L				10d. IN	SIDE CITY	
	10e STREET AND NUMBER	Cecil		Elkto				1 🗆 Y	ES 2 NO	
	664 Appleton I	Road		101. ZIP CODE 10g. C				U.S.A		
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 (X) YES IF YES, GIVE WAR OR DECEDED TO THE SECOND STATE OF THE SECOND STAT	2 NO	If ye	DECENDENT OF HISPA s, specify Cuben, Maxic YES 2 X NO Speci	an, Puerto Rican, etc.	Yes or No—	14. RACE Ame Black, White, Specify: W	etc.	
3	15. DECEDENT'S EDU (Specify only highest grad	JCATION le completed)	18e. DECEDENT'S	work done dude	PATION g most of working	16b. KIND OF	BUSINESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT (	use retired.) enance		Gar	neral 1	Motors		
	17. FATHER'S NAME (First, Middle, Last)		11012110	- Indire		AME (First, Middle, Mai		MOCOLS	·	
	James C. Rigg	Js				y Alice				
2	19a. INFORMANT'S NAME (Type/Print)	D.1	19b. MAILIN	G ADDRESS (Str	eet and Number or Rural	Route Number, City or	Town, State, Zip C	Code)		
	Mary Katherine Riggs 664 Appleton Rd., Elkton, Md. 2192									
	1\(\tilde{\Delta}\) Burlet 2 \(\tilde{\Delta}\) Cremetion 3 \(\tilde{\Delta}\) Removal from State (cematory or other place)									
	21. BIGNATURE OF FUNERAL SERVICE LI	CENSEE	ilpin .		Memoria.	Park	Elkto:	n, Md.	. 57	
	23. PART I. Enter the diseases, or			See	FUNCRAL		Elkton 59 E. Elkton		2-192	
	iMMEDIATE CAUSE (Final disease or condition resulting in death)		A CONSEQUENCE C	Finfact	011				nset and De	
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):									
במוסיד סבייווו וכעו וסוג									UTOPSY FINDIN	
							2 NO	OF DEAT		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH Y	ES   NO	☐ UNCERTAI	NΠ		1   YE	8 2 NO	
THI SICIAN.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	ATH (Check only o						
	1 TYES 2 THO	1 Conpetient 2 ER/Outs			Home 5 - Rasidence	8 Other (Specify)				
- 10	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIR	JURY	INJURY AT WORK?	28d. DEŞCRIBE HO	W INJURY OCCU	RED		
- 17	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	f — At home, ferm,		YES 2 NO	281. LOCATION (Str	ent and Number or	Rural Bruta Alun	shar	
	4 Homicide determined			occurred at the time, date end place, end due to the cause(s) end manner as atated, stigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and manner a						
	29a, CERTIFIER (Check only					time, data and place			nner as stated	
	29a, CERTIFIER (Check only	ER: On the besis of examination					, end due to the			
o pe comit ce leu al	290. CERTIFIER (Check only one)  1 CERTIFYING PHYS 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE	ER: On the besis of examination	en end/or investigation	on, in my opinio	n, death occured at the	MBER	, end due to the	cause(s) and ma		

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

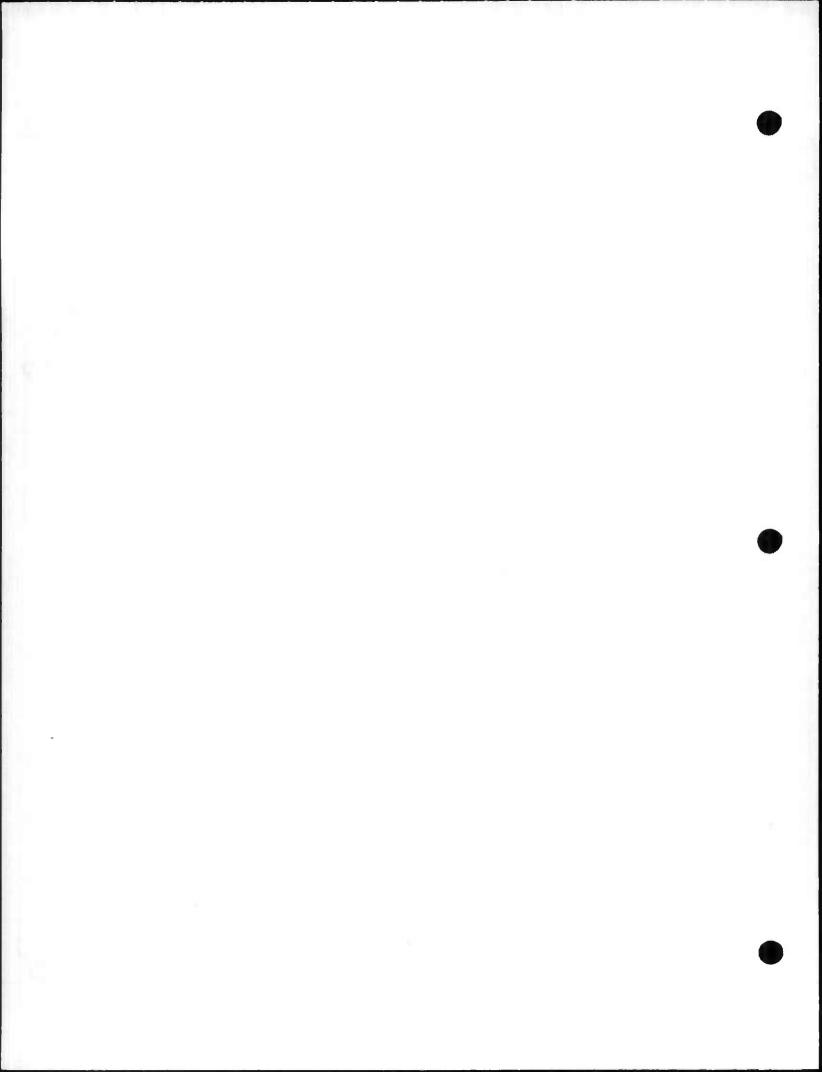
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MRORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	TIEGIOTTIAN				CAIL	FUEAIR		REG. NO.				
	1. DECEDENT'S HAME (First, Middle, Last)	ON		R	IVE	PC	2. DATE MONTH	OF OEATH	NY .	YEAR	TIME OF DEATH	
	4. SOCIAL SECURITY HUMBER		E (In yrs. last	A feet of male	, , , ,		11.4.		, 19	195	3,43AH	
	299-26-8316		63		MONTHS DAYS		(Month	OF BIRTH 1. Day, Year) E 25,	1931	GEOI	ACE (State or Foreign	
- 1	9e. FACILITY HAME (If not institution, give st	reet end number)			9b. CITY, TOW	N OR LOCATION OF D		2 23,		NTY OF DEA		
DIRECTOR	PRINCE GEORGES HO	OSPITAL HCE	NTER	CHEVERLY					PRIN	PRINCE GEORGES		
2	10e. STATE 10b. COUNTY			10c. CITY	TOWN OR LOC	CATION	_			1	Dd. INSIDE CITY	
		NTGOMERY		TAK	OMA PA	RK				- 1	LIMITS?	
₹ I	100. STREET AHD NUMBER					101. ZIP CODE		- 1	10g. CITI	ZEN OF WH	AT COUHTRY?	
E I	&&L) MAPLE AVENUE	<u> </u>				20912			UNI	CED ST	TATES	
FUNERAL	11. MARITAL STATUS  1 Never Married 2 K Married	12. WAS DECEDENT EVER FORCES? 1 YE	S 24 NO	IED O	13. WAS D	ECENOENT OF HISPA specify Cuben, Mexic	NIC ORIGIN	? (Specify Yes	or Ho-	14. RACE -	- American Indian, Vhite, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES			ES 2 X NO Speci		,		Specify:		
	15. DECEDEHT'S EDUC (Specify only highest grade	ATION completed)	16a. DEC	EDENT'S L	SUAL OCCUPA	TION	16b.	KINO OF BUS				
COMPLETED	Elementery/Secondery (0-12)	College (1-4 or 5+)	Hife. L	DO NOT USE INTER	retired.)	most or working		SELF E	MPLOY	ΈD	9.0	
MO	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME /First A	distriction is desired as	0			
BE C	JOHN HENRY RIVERS					CHRIST			Surname)			
10	190. INFORMANT'S HAME (Type/Print) ELSIE C. RIVERS	(WIFE)				VENUE, TA					)	
					FDISPOSITION		DATE					
	20e_METHOD OF DISPOSITION 11.5 Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)		emetery, crem	NGTON	er place) NATIO	NAL CEM.	6/3			Oity or Town	RYLAND	
	21. SIGNATURE OF FUNERAL SERVICE INC	ENSEE				AND AODRESS OF FA		TITLED	4.7. 77	OME		
	> My S Py	un.		M859	5538	ANDER S. MARLBORG	PIKI	E, FOR	ESTV	ILLE,	MD 20747	
	23. PART I. Enter the diseases, or contact the service of the serv	omplications that caus list only one cause on	ed the dee	th. Do no	ot enter tha n	node of dying, suc	ch es cerd	sc or respli	ratory arm	est,	Approximata	
	IMMEDIATE CAUSE (Final							,			Onset and Death	
	disesse or condition resulting in desth)	MYGO	CARI	ALC	L 1	NFARC	Tio	N			UNK	
		DUE TO OFF AS	A CONSEOL	JENCE OF)	:						16.7	
NO.	Sequentially list conditions,	OUE TO (OR AS	A CONSEQU	JEHCE OF								
¥	If any, leading to immediata cause. Enter UNDERLYING										İ	
Ĕ	CAUSE (Disease or injury that initiated events	OUE TO (OR AS	A CONSEOU	JEHCE OF)	:							
CERTIFICATION	resulting in death) LAST											
	PART II. Other significent conditions	contributing to deeth	but not res	sulting in	the underly	ing ceuse given in	Part I.	24s. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS	
EDICAL	71					12		PERFOR		AV	MILABLE PRIOR TO OMPLETION OF CAUSE	
							- 1	1 YES 2	No		DEATH?	
2 7	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEAT	H YES	□ NO □	UNCERTAI	$\overline{N}$			'	☐ YES 2 ☐ HO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OF DEATH	Check only on							
YSI	1 TYES 2 7 NO	1 Inpatient 2 ER/Ou	stpatient 3		OTHER: (  Nursing He	ome 5 Residence	6 🗆 Other	(Specify)				
H H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME INJU		NJURY AT	28d. DEŞ	CRIBE HOW IN	JURY OCC	URED		
À	1 Hatural 5 Pending 2 Accident Investigation				M 1	YES 2 NO						
_	3 Suicide 8 Could not be determined	RY — At hom- pecify)	e, ferm, sti	rest, factory, of	Nice	28f. LOCA City o	TION (Street er	nd Number	or Rural Rout	e Number,		
COMPLETED												
릴		CIAN: To the best of my kno										
Į į	2 MEDICAL EXAMINER	: On the basis of examinat	ion end/or im	veatigation	, in my opinion,	death occured at the	time, date	end place, end	due to the	cause(e) er	nd menner ee stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI	MBER		29d. DATE	SIGNED (M	onth, Day, Year)	
	Offseryen M	D				D 259	25		M	44 3	0, 1995	
-	M. HAME AND ADDRESS PERSON WHO	COMPLETED CAUSE OF O	TAN	27) (Type, F	Cont CIA	Ave,	BeTL.	ed	en.	2	2814	
	31. DATE FILED (Month, Day, Year)	32/REGISTRAR'S SIG	NATURE	נוש	W	AVVI	- 1 N		IVEC		• /	
ŀ	31. DATE FILES MOTHS. Day Meet 1995	Julia d'aude	or Rand	all								
بالسب					<del></del>							

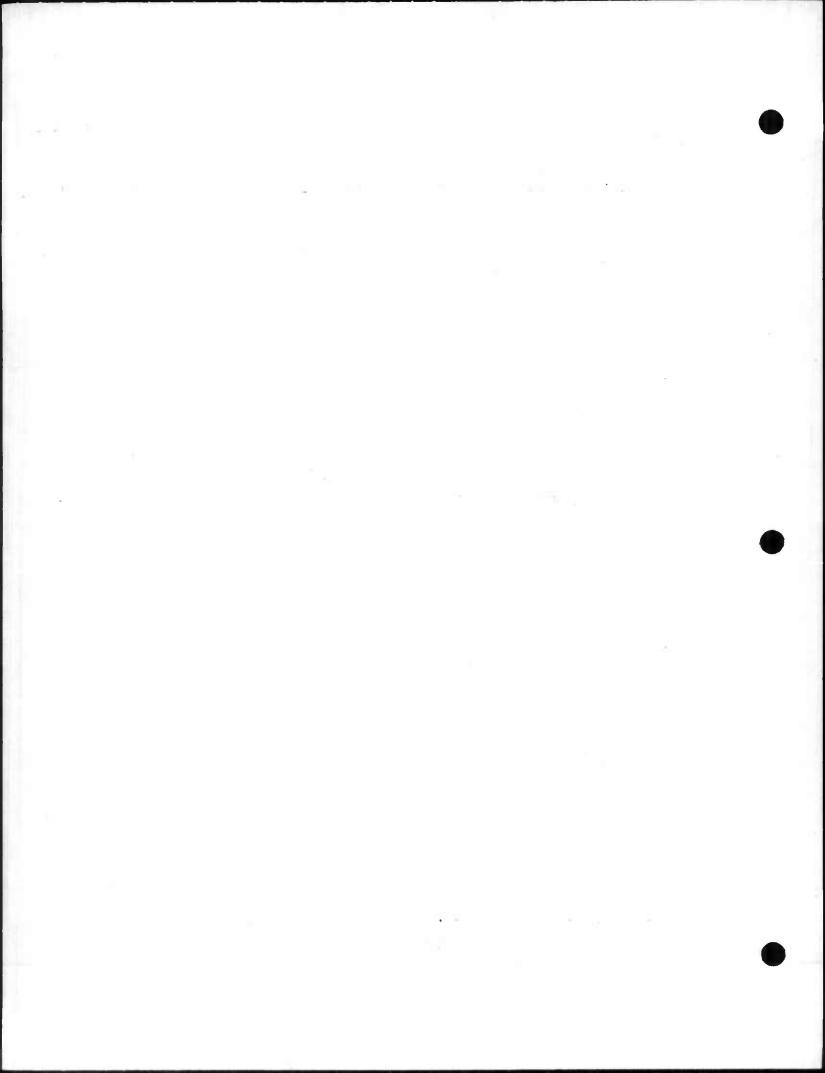


FOR

spital or attending physician.	ed for use as the burial-transit permit. Pages 1.2.3 should		
HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	e fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any inlury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - STATE REGISTRAR		ICATE O			MENIAL DI	G. NO.	2			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE			YEAR	3. TIME OF DEATN	
	SHERON MONICA ROBB					MAY 2	7,	1995	TEAR	5:30p.m. M	
	4. SOCIAL SECURITY NUMBER 5.77−98−3003 5. SEX 1 □ M 2 ★ F 47	yrs. last birthday) YRS.	IF UNDER 1 YEAR		24 HRS.	7. DATE OF BIN (Month, Day, Aug.	Year?	1947	Countr	PLACE (State or Foreign y) nama	
	8e. FACILITY NAME (If not institution, give street end number)		9b. CITY, TOW	OR LOCATION	ON OF DE		,		NTY OF D		
DIRECTOR	DOCTORS COMMUNITY HOSP	ITAL	LANH	AM -SI	EABR	OOK		PRIN	ICE (	GEORGE'S CO.	
EC.	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOC	ATION			_			10d, INSIDE CITY LIMITS?	
	Maryland PG	Gre	enbelt							1X YES 2 NO	
FUNERAL	8567 Greenbelt Rd.			20207				_	zen of w	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced  12. Was DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 [X] NO	NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc.						- American Indian, t, White, etc. b: Panamian		
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCUPA	TION		16b. KIND	OF BUS	INESS/IND	USTRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	Nur		ng .	Pri	ivat	e			
CON	17. FATNER'S NAME (First, Middle, Last) Ambroce Johnson					ME (First, Middle, in Quint		Surneme)			
BE	19s. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Stree			Poute Number, City		State 7in	Code		
2	Jacinto Williams	5113	Just St	., N.	E. W	lash., I	). C	. 20	019		
	20s. METHOD OF DISPOSITION 1.□ Burlie! 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Spoots)	PLACE AND DATE Of tery, cremetory or of Harmon	ther pleca)	Name of		6/5/95		ndov			
	21. SIGNATURE OF FUNERAL SERVICE LICENSIAE		22. NAME	AND ADDRES		ral Hon		iido v	<u></u>		
	Stanley D. Barry	0697	2504	28th	St.	. N. E.	. Wa	sh.,	D.	C	
	23. PART L Enter the diseases, or complications that sused shock, or heart failure. List only one cause on each	the death. Do r ch line.	not enter the m	ode of dyi	ng, auch	h aa cardiac o	r reapir	atory arr	eat,	Approximata Interval Between	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. SEPT C SHOCK  DUE TO (OR AS A CONSEQUENCE OF):										
	The Action of th										
NO	Sequentially list conditions,  DACTERENIA AND FUNCERIA  DUE TO (OR AS A CONSCOUENCE OF):										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  UNDERLYING  CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):										
FIE	an auditor to de about 1 AOT	CONSEQUENCE OF									
CAL	PART II. Other algoriticant conditions contributing to death but	not resulting i	n the underlyi	ng cause g	iven in l	F	PERFORI		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
MEDICAL	ASTMMA					_   1	YES 2	₹ NO		COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YE	s 🗆 NO I	JUNC	ERTAIN	<u> </u>				1 YES 2 NO	
PHYSICIAN:		L PLACE OF DEAT	H (Check only on								
YSi	1 VES 2 NO 1 Inpetient 2 ER/Outpet	lent 3 🗆 DOA	OTHER: 4  Nursing No	me 5 🗆 Re	sidence	6 🗆 Other (Spec	:ify)			7	
ву Рн	27. MANNER OF DEATH  1. Natural 5 Pending 2 Accident Investigation	28b, TIM INJ	URY	JURY AT ORK? YES 2	] NO	28d. DESCRIBE	HOW IN	JURY OCC	CURED		
	3 Suicide 6 Could not be determined 28a. PLACE OF INJURY - building, etc. (Specify	- At home, farm, s	street, factory, off	Ice		281. LOCATION City or Town		nd Number	or Rurel A	oute Number,	
Ä	29e. CERTIFIER (Check only (Check only Inc.)	ige, death occurre	d at the time de	le and place	and due	to the course(s)	ad man				
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination of									and menner se stated.	
BE	29b. SIGNATURE AND TITLE OF CENTIFIER			1	NSE NUM	BER				(Month, Day, Year)	
ဥ	30. NAME AND ADDRESS OF PLASON WHO COMPLETED CAUSE OF DEAT	M (ITEM AT AT	Defeat)	MD3	1069			May	1 31,	1995	
				wan 1	anha	m UD	207	0.6			
	Dr. George H. Bone 9602F M. L  31. DATE FILED (MONTH, Day, Year)  JUN 01 1995	une .	on nagni	vay L	uriridi	m, MV	20/	00			
	JUN 01 1995 Jeli Davdsor Ras	lath									



TO THE MOSFITM OF ATTENDING PHYSCIAN. The law requires that the death certificate be executed with couns after death. Page 6 may be retained by the hospital or attending physician.

THE PHYSTAL DIFFICURE After the execution has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be need within 72 hours after death with the State Legit. Or thealth and Mental Hygiene prior to burial, cremation, or removal.

IN THE PHYSTAL II I have 26 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

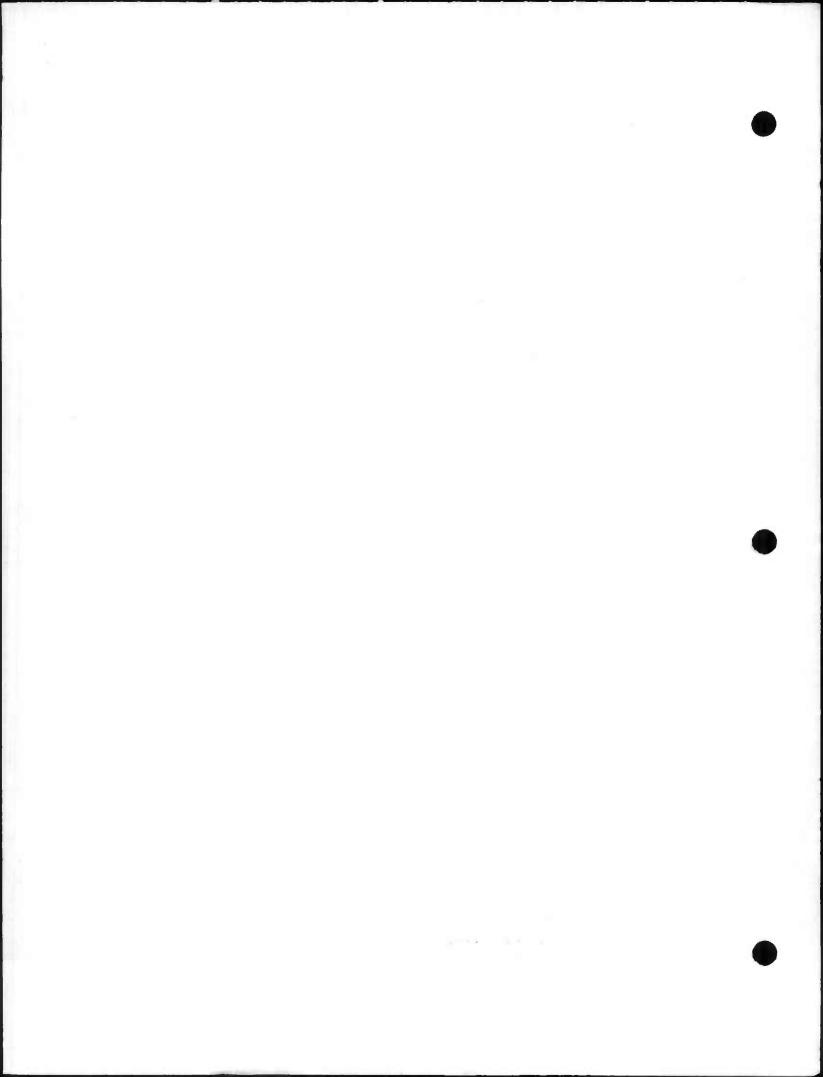
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICATE (	OF DEATH	REG. N	Э.			
į	1. DECEDENT'S NAME (First, Middle, Last)  MARY GRAY B.	ADMEC DODE	Duc ON				DAY	YEAR	TIME OF DEATH	
	MARI GRAI B.		(In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	May 28	199		:40 P. M	
į	244-42-8230	1 🗆 M 2 📉 F	63 YRS.	MONTHS DA	YS HOURS MIN,	Feb. 15		Co.	GE (State or Foceign Granville N.C.	
DIRECTOR	90. FACILITY NAME (If not institution, give stage 1906 Loughran				Washing			NTY OF DEAT	George's	
2	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	r	10c. CIT	Y, TOWN OR L	OCATION			10	d, INSIDE CITY	
L DIR	Maryland Prin	ce George'	s	Fort	Washing	ton	,	13	LIMITS? YES 2 NO	
FUNERAL	8906 Loughran	Terrace			20744			ited	States	
B	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR O	2 XNO	ARMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify V. II yes, specify Cuben, Maxican, Puarto Rican, etc.)  1  YES 2 X NO Specify:				Specify:	American Indian, nite, atc.	
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S		PATION a most of working	16b. KIND OF B	USINESS/IND	USTRY		
COMPLETED	Elementary/Secondary (0-12) 8 th	College (1-4 or 5+)	life. Do NOT us	lerk	Those of Hostony	Pri	vate			
E CON	17. FATHER'S NAME (First, Middle, Last)  James Barnes			~~.		AME (First, Middle, Malde Tinnie Wi		son		
TO BE	19a. INFORMANT'S NAME (Type/Print) Esther Vaughn		19b. MAILING	AODRESS (St	eet and Number or Rural	Poute Number, City or To Drive, Ch	wn, State, Zip	Code)	N C	
	METHOD OF DISPOSITION  1 Burlel 2 Cremetion 3 Remo	ovel from State Cou	D. PLACE AND DATE	OF DISPOSITIO	N (Name of	OATE 20c. L	OCATION	City or Town	State	
	Deputition 5 Other (Specify)  21. SCINATURE OF FUNERAL SERVICE LICE	ENSTE /	edar H		emetery  E AND ADDRESS OF F	6/1/95 S	uitla	and,	Md.	
	John T.	Hewaii	1 111	- STE	WART FU	NERAL HON		Wash	D.C.	
	1. Enter the disease, or o shock, or heart failure.  IMEDIATE CAUSE (Final disease or condition resulting in death)	complications that ceuse List only one ceuse on e	d the deeth. Do reach line.	AN	mode of dying, sur	ch aa cardlec or rea	piratory arr	est,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST									
MEDICAL	PART II. Other significant condition	s contributing to death is	out not resulting	in the under	lying cause given in	Part I. 246. WAS A PERFO	N AUTOPSY DRIMED? ZX NO	CO	HE AUTOPSY FINDINGS MLABLE PRIDE TO MPLETION OF CAUSE DEATHY YES 3 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL		OTHER:	B. PLACE OF DEATH (C)	heck only one)				
I X	1 YES 2 NO 27. MANNER OF DEATH	1   Inpatient 2   ER/Outs		4 - Nursing	-	6 C Other (Specify)				
BY PH	1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	WORK?	28d. DESCRIBE HOW	MJURY OCC	UNED		
_	3 Suicide # Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe.	r — At home, tann, r city)	street, factory,	office	Ser. LOCATION (Street City or Yeart, State	and Number II	or Hurel House	Mumber.	
COMPLETED		CIAN: To the best of my know							od manner as stated	
BE CC	296 SIGNATURE AND TITLE OF CENTIFE		F1 ()		29c DICENSE NU		_		onth, Day, Year)	
ğ	30. NAME AND ADDRESS OF RERSON WITH	O COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Tyge,	Print)	17/4/	391	m	My 2	1995	
	1575 lheen	may &	Leenhe	um	1.2	0770		0		
- 1	MAY 31 1995	22. REGISTRAR'S SIGN	ATURE				· -			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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											95		865	6
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMENT	OF H	EALTH DEAT	AND N	MENTAL	HYGIEN				
- 3	1. OECEDENT'S NAME (First, Middle, Las	1)								OF DEATH	-		3. TIME OF DE	ATH
0	Albert	G.	R	INNE					Mav			995	9:30	Рм
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1	1 YEAR	IF UNDER	24 HRS.	7. DATE C	OF BIRTH			PLACE (State or	
1	211-14-0523	1 📉 M 2 🗆 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	1025	Country	1)	
	9a. FACILITY NAME (If not institution, give	atreet and number)			9h CITY	TOWN C	R I OCATE	ON OF DE		. 0,		NTY OF OF	nsylva	nia
Œ	3 Grouse Run Roa	ad							A111					
18	RESIDENCE OF DECEDENT	<u> </u>				Ua	aklar	10			Gé	irret	t	
DIRECTOR	10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN OF	R LOCAT	ION	_					10d. INSIDE CI	ΓY
₫	MD	Garrett		1	0al	klar	nd						LIMITS?	NO DA
A	10e. STREET AND NUMBER					101	ZIP CODE	E			10g. CIT	ZEN OF W	HAT COUNTRY	
E	3 Grouse Run Roa	ad						2.1	.550			USA		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. W	AS DEC	ENDENT C	F HISPAN	IC ORIGIN	(Specify Yes	or No-		- American In	dian
ВҰ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE Y	Mar or dates ean War	40	1	yes, spe	2 ZNO	n, Maxican Specify:	n, Puerto R	Ican, etc.)		Specify	- American In White, atc.	
8	15. OECEDENT'S ED (Specify only highest gre	UCATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N .		16b.	KIND OF BUS	SINESS/INC	DUSTRY	17113.1	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	(Gi	Do NOT u	work done du se retired.)	uring mo:	st of workin	g	1150					
릴	12		′	Plu	mber				1	P1	umbin	12		
0	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NAM	ME (First, M	iddle, Melden		0		
	Albert H.	Rinne						mily		0.	Bu	11		
BE	19a. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS	(Street a				er, City or Tow				
2	Cheryl Wilkeson													
	Cheryl Wilkeson 1630 Annette Ave., Library, PA 15129  20a. METHOD OF DISPOSITION 1 X Burilai 2 Cremation 3 Removal from State Congetery, crematory og other place)  20b. PLACE AND DATE OF DISPOSITION (Name of congetery, crematory og other place)													
	1 🕅 Buriel 2 🗆 Cremation 3 🗆 Re 4 🗆 Donation 5 🗆 Other (Specify)	moval from State	cemetery cres	matory or o				0 237	1			•	rn, ouna	
	21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE	- I Queen	11 01						Lib	rary,	PA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Stewart Funeral Home  32 S. Second St., Oakland, MD								MD '	21550					
	23. PART i. Enter the diseases, or	complications tha	t caused the de	eth. Do r	not enter t	the mo	de of dyl	ng, such	ae cerdi	ec or reepi	ratory an	reet,	Approxir	nete
	snock, or neart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Finel  Onset and Deeth													
	disease or condition													
	resulting in death)  • Ventricular Arrhythmia, Acute  Due TO (OR AS A CONSEQUENCE OF):											Sudd	en	
-	T1 '- II Di												l ye	0.20
ō	Sequentielly list conditions, if any, leeding to immediate	U.	(OR AS A CONSEC										T Ac	ar
*	cause. Enter UNDERLYING	Arteri	osclerot	ic C	ardio	-Va	scul	ar D	iseas	se			Unkno	พท
ERTIFICATION	CAUSE (Diseese or injury that initiated events	U-	(OR AS A CONSEC								-		-	
F	resulting in death) LAST	4												
2													+	
MEDICAL	PART II. Other eignificant condition	one contributing to	deeth but not re	esuiting	in the und	lerlying	ceuse g	iven in F	Part i.	24s. WAS AN PERFOR			WERE AUTOPSY	
8										1 TES 2			COMPLETION OF OF DEATH?	
Ä												- 1	1   YES 2	NO
ä	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEAT	TH YE	S   N	0 🗆	UNC	ERTAIN	I EE					
<u>₹</u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	TH (Check on	nly one)			AZZ					
Sic	1 TYES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 [X] Ra	sidence 8	□ Other	(Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF (Month, D		28b. TIM	E OF 2	8c. INJL	JRY AT		_	RIBE HOW I	NJURY OCC	CURED		
BY	Natural 5 Pending		ay, re-ei/)	1147	URY	1   Y	ES 2	NO						
0 8	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY — Al hor	me, farm, s	streel, factor	ry, offica		1	28f. LOCA	TION (Street a	nd Number	or Rural Ro	oute Number.	
ш	4 Homicide detarmined	bullaing,	etc. (Specify)						City or	Town, State)				
COMPLET	29s. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the hard of	Proc knowledge - d	ath car			-4 .				7.4			
M		SICIAN: To the best of IER: On the bests of a											104 10 to 100 to	
8			/ VIOLOT WINDOW II	อสเเปียเเบ	iii my opi	······································	witti OCCUM	ed at the ti	iitte, data 4	ma place, en	o oue to th	e ceuse(s)	and manner as	atated.
HH H	296. SIGNATURE AND STILE OF CERTIES	7/4	1/	2	0			NSE NUME					Month, Day, Year	)
2	Harpert 1	n dan	Mon	, In	0		D (	05658	8		► Ma	ay 31	, 1995	
-	36. NAME AND ADDRESS OF PERSON W	HO COMPLETED DATE	SE OF DEATH (ITEM	4 27) (Type,	Print)									

Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland

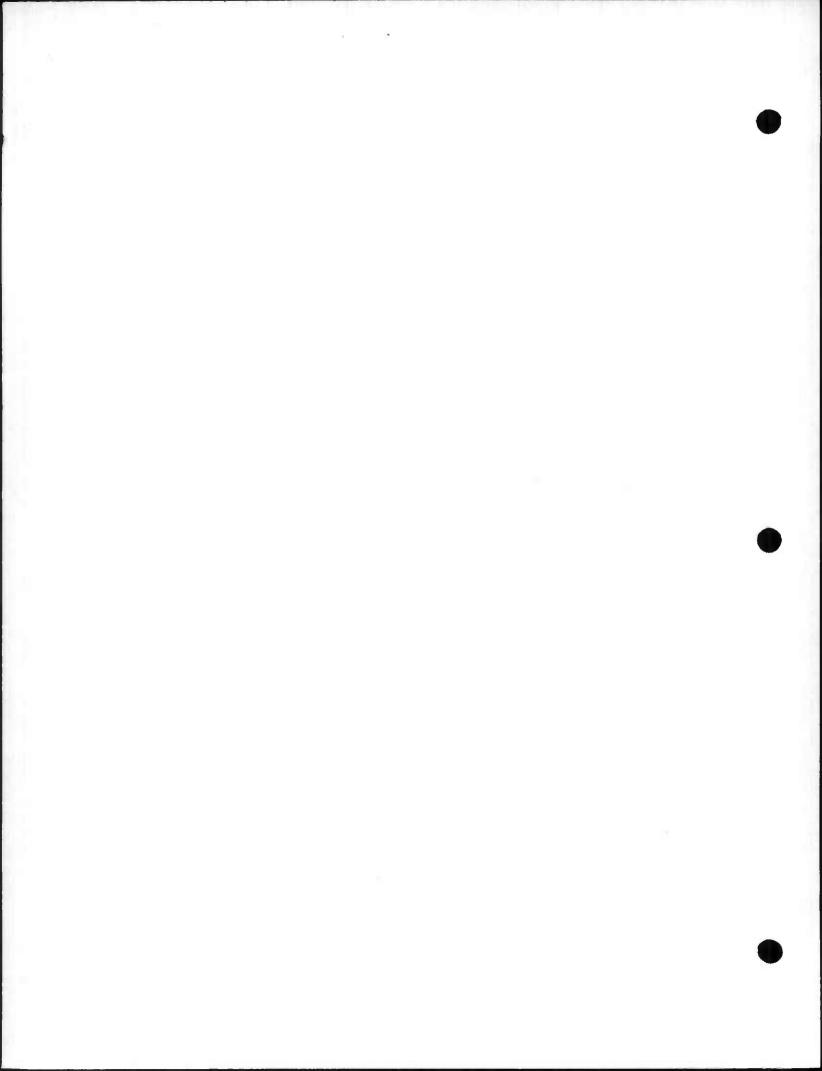
DATE FILED (Month, Day, Year)

7 1995

Alia Streets Signature

31. DATE FILED (Month, Day, Year)
7 1995

21550

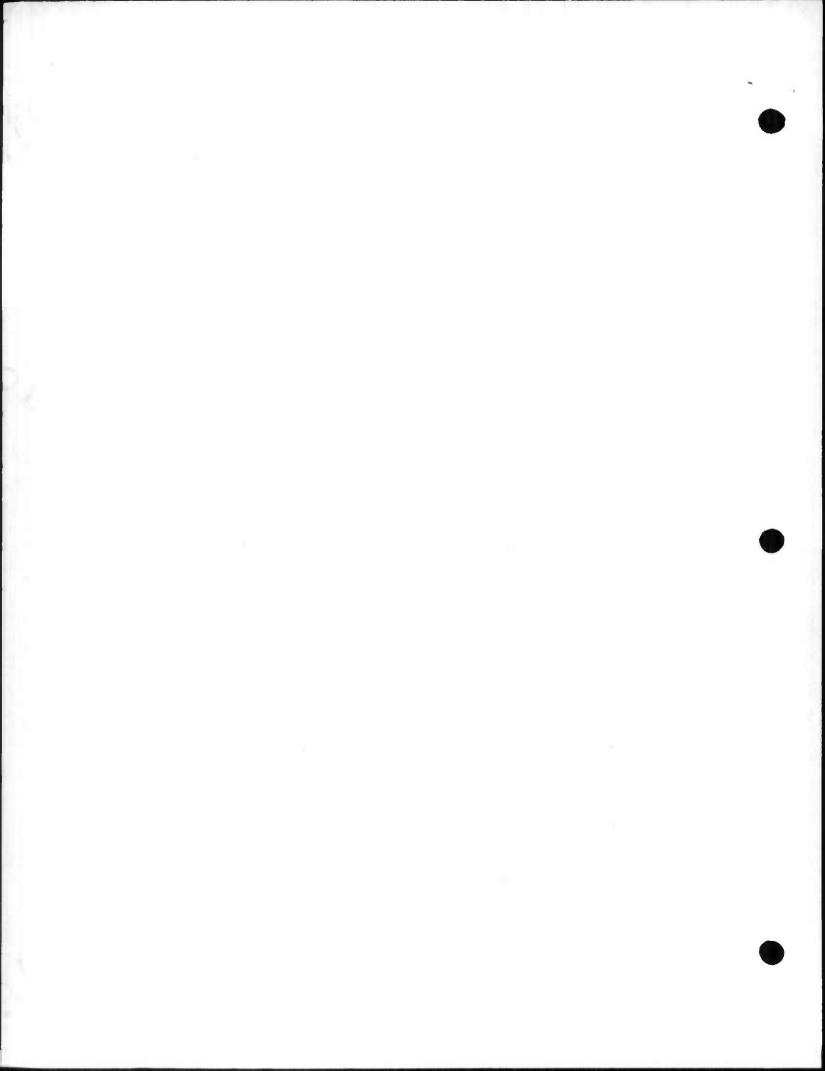


stained by the hospital or attending physician. should be detached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

DALLIMORE, MARTLAND	hours after death. Page 6 may be retained by the hosp	led in by the funeral director, page 5 should be detached. Or removal.	medical examiner must be notified at once.	
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	HEALTH AND		YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				D LI TITI	2. DATE OF D	EATH	3. TIME OF DEATH	
	Ralph L. Rober	ctson Sr.				June	8 199	95 8:30 AM	
	4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH	8. BIRTHPLACE (State or Foreign	
	217-18-8356	1 💢 M 2 🗌 F	79 YRS.	MONTHS DAYS	HOURS MIN.	Feb 4	1916	Maryland	
~	9a. FACILITY NAME (If not institution, give a			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUN	ITY OF DEATH	
DIRECTOR	1411 Old New W	Vindsor Pik	е	Westm	inster			Carroll	
E C	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY	
PHO	Maryland Carr	coll	W	estmins	ter			LIMITS?	
AL	10e. STREET AND NUMBER				. ZIP CODE		10g, CITIZ	ZEN OF WHAT COUNTRY?	
FUNERAL	1411 Old New N	Vindsor Pik	е		21158		1 '	ted States	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Sp		14. RACE — American Indian, Black, White, etc.	
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES			ecify Cuben, Mexic 2 NO Speci		etc.)	Snectly:	
								white	
COMPLETED	15. DECEOENT'S EDU (Specify only highest grade	completed)	(Give kind of the Do NOT ::	USUAL OCCUPATION work done during mose retired.)	ON st of working	16b. KIND	OF BUSINESS/IND	USTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)							
NO.	17. FATHER'S NAME (First, Middle, Last)		dalry	farmer		dai	Y Walden Surname)		
BE C	William H. Rob	ertson			Alice		Crawmer		
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a			y or Town, State, Zip	Control	
5	Ralph L. Rober	tson Jr.						tminster, MD	
	20e. METHOD OF DISPOSITION 1 1 Burlel 2 Cremetion 3 Rem	20b.	PLACE AND DATE	OF DISPOSITION /Na	me 6/10/	95 DATE	20c. LOCATION — C		
	4 Donation 5 Other (Specify)			ther place) 3. Churc		,	Westmi	nster, MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	D ADDRESS OF FA	ICILITY T			
	Katherine 4	Ritto - Nurit	Ter .	Pri	Uts Ful	neral	Home &	Chapel	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. Liet only one cause on each line.								
	immediate cause (Final	Liet only one ceuse on ee				interval Between Onset and Death			
	disease or condition resulting in death)	. Sipsi	•					18 m	
	11: 31-00:5-22	OUE TO OR AS A	CONSEQUENCE OF	Ps: 0 1	10	4		15	
NO	Sequentially list conditions,	Amyot	wphie	Inter	nl S	eleso.	sis	134	
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING	DUE TO IQA AS A	CONSEQUENCE OF	P)c		•			
임	CAUSE (Disesse or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF	n.					
FE	reaulting in deeth) LAST		0011024021102 01	,					
		3.			- 11				
AL	PART ii. Other significent condition	s contributing to deeth bu	it not resulting i	n the underlying	ceuse given in		WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS	
MEDIC	- None						YES 2 AO	COMPLETION OF CAUSE OF DEATH?	
M								1 TYES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTR		200		UNCERTAI	N 🗆			
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEAT	OTHER:					
IYS	1 YES 2 DO	1 Inpatient 2 ER/Outpa		4 Nursing Home					
	Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY WO	RK?	28d. DESCRIBE	HOW INJURY OCC	UREO	
à	2 Accident Investigation	28e. PLACE OF INJURY	At home form		ES 2 NO				
COMPLETED	3 Suicide 8 Could not be detarmined	building, etc. (Specif	(y)	treat, vectory, orne		City or Town	(Street and Number on, State)	or Rurel Route Number,	
	29a. CERTIFIER 1 CERTIFYING PHYON	CIAN. To the best of a least				uran samuel	Service will be stated		
MP	(Check only one)  2 MEDICAL EXAMINE	CIAN: To the best of my knowle R: On the basis of examination	and/or investigation	n. In my opinion, data	and place, and due	to the cause(a) a	and manner as state	d. cause(s) and manner as atated.	
	296. DIGNATURE AND TITLE OF CERTIFIER			1					
BE	Athen has	414			29c HICENSE NUI	WER VV2	29d. DATE	SIGNED (MINTE, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OFA	TH (ITEM 27) (Туре,	Print) -	-3	rro	1	1817	
	0688 POH	le Rond	We	stone	when	m	1 21.	157	
	JUN () 8 1995	62. REGISTRARIO SIGNA	TURE						



retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hursal-transit narmin brane 1.2 serval	The state of the s	notified at once.	
HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ysician and completely filled in by the funeral director, page 5	prior to burial, cremation, or removal.	sd, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
NDING PHYSICIAN: The law requires that the death certifical	3: After this certificate has been signed by the attending phy	ir death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other	
TO THE HOSPITAL OR ATTENDING PHYSI	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with t	IMPORTANT: If item 28 is marked,	

AMY BENNETT RICHARDSON  4. SOCIAL SCURITY NUMBER  5. SEC. ADE (IN 1912 LAND FUNCIS) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1 SEC. ADE (IN 1912 LAND FUNCIS ) THAN I FUNCIS 1	1. DECEDENT'S NAME (First, Middle	e. Lest)							A DATE OF SECTION			
4. SOCIAL SECURITY MANE (If the Principles of Apple 24 to 5.1)  4. SECURITY MANE (If the Principles of Apple 24 to 5.1)  4. SECURITY MANE (If the Principles of Apple 24 to 5.1)  4. CATY, TOWN ON LOCATION  4. CA		HARDSON					2. DATE OF DEATH MONTH MAY 27 1	DAY QQ5	YEAR	3. TIME OF DEATH		
214-05-6281  1- 12 - 17 - 18 - 18 - 18 - 18 - 18 - 18 - 18					. last birthday)	IF UNDER 1 Y	EAR IF UNDER	R 24 HRS.	7 DATE OF BIRTH		a RISTI	HPLACE (State or Foreign
Secretary NAME of the bittleness, per sense and number)  Secretary Name of the art Heapthal  Residence of december 1 and	214-05-6281	10	M 2 XF			MONTHS D.	AYS HOURS	MIN.	(Month, Day, Year)	1911	Count	(ry)
THE STREET AND INJUSTICES  100. STREET AND INJUSTICES  11. MAINTAL STRUES  11. MONTH METHER STRUES  11. MONTH METHER STRUES  12. TANGE CORDETT FOR IN I.S. SAME  11. MONTH METHER STRUES  12. SOCIEDATE SUCCIONO  12. STREET AND INJUSTICES  12. MONTH MAINTAL STRUES  12. MONTH METHER STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  12. MONTH MAINTAL STRUES  13. MONTH MAINTAL STRUES  14. MONTH AND ADDRESS (STRUE MAINTAL STRUES)  15. MONTH MAINTAL STRUES  16. MONTH MAINTAL STRUES  16. MONTH MAINTAL STRUES  16. MONTH MAINTAL STRUES  17. MONTH MAINTAL STRUES  18. MONTH MAINTAL STRUES  18. MONTH MAINTAL STRUES  18. MONTH MAINTAL STRUES  19. MONTH MAINTAL STRUES  19. MONTH MAINTAL STRUES  10. MONTH MAINTAL STRU		n, give street a	nd number)			9b. CITY, TO	WN OR LOCATI	ION OF DI				0
No. STREET AND NUMBER   No. COUNTY   No. CITY, TOWN OR LOCATION   Frostburg   No. STREET AND NUMBER   NO. STREET AND NUMBER			tal	· .		G	umberl	and	14			
11. First AND NUMBER  11. MANIFICAL STUDE  11. MANIFICAL STUDE  11. MANIFICAL STUDE  11. MANIFICAL STUDE  11. MANIFICAL STUDE  11. MANIFICAL STUDE  11. MANIFICAL STUDE  12. MAD DECEDENT EVER IN U.S. ASMED  13. MAD DECEDENT OF HISTORIA COMMENT (Specify Yes or New Yes, or	10e. STATE 10b.	COUNTY	gany						4			LIMITS?
The MANTAL STATUS   NAME   Committed   12   Mantal   13   Mantal   15   Mantal   15   Mantal   15   Mantal   16	10a, STREET AND NUMBER						10f, ZIP COD	E		10g. Cl	TIZEN OF	
1. Mean Marked 2   Marriad   12. Ms DECEDENT FUTEN IN U.S. AMBED   PROCESS   1 YES 2   10   1   YES 2   10   1   YES 2   10   1   YES 2   10   1   YES 2   10   1   YES 2   10   1   YES 2   10   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 2   YES 3   YES 2   YES 3   YES 2   YES 3   YE	114 Frost	Ave.					2	1532			U.S.	Α.
Biomediary   Secondary (0-11)   College (1-4 or 5-1)   College (1-4 or 5-1)   College (1-4 or 5-1)   College (1-4 or 5-1)   Homemaker   Own Home   Own Hown Home   Own Home   Own Home   Own Home   Own Home   Own Home	1 Never Married 2 Merrie	id F	FORCES? 1	YES 2	ABMED NO	If ye	s, specify Cube	ın, Mexica	n, Puerto Rican, etc.)		14. RACI Blac	E — American Indian, k, White, etc.
Sementary/Secondary (0-12)   College (1-4 or 5 -)   Short we relieved.)				16a.	. DECEDENT'S	USUAL OCCU	PATION		16b. KIND OF B	USINESS/IN	DUSTRY	MITTER
TO, FATNER'S NAME (Pirst, Micdis, Last)  Frank Bennett  196. MALING ADDRESS (Street and Number or Russ)  197. METHOD OF DISPOSITION PROPERTY  206. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  206. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  206. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  207. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  208. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  208. PLACE AND DATE OF DISPOSITION Number of General Rosen Number or Russ)  21. SIGNATURE OF FUNEAUS SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, interval Bath of Season or condition  22. NAME AND ADDRESS OF FACILITY  23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, interval Bath or resulting in death)  24. WE AND ADDRESS OF FACILITY  25. PLACE AND ADDRESS OF FACILITY  26. DATE OF NAME AND ADDRESS OF FACILITY  27. NAME AND ADDRESS OF FACILITY  28. DATE OF NAME AND ADDRESS OF FACILITY  28. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FACILITY  29. DATE OF NAME AND ADDRESS OF FA		1		-)				ng				
Trank Bennett   Dora Orndorf	17 SATNED'S NAME /Elms Middle I	and)			HOM	emak er						
The MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Ellen Richardson  1703 Bolton St., Baltimore, Md. 21217  200, METNOD OF DISPOSITION   1/0 Burlet 2   Cremention 3   Ramoval from State   200 Electron State   200 Elect							18. MOT	-		n Sumame)		
Ellen Richardson  1703 Bolton St., Baltimore, We bein, Sim Jobson  1703 Bolton St., Baltimore, We bein, Sim Jobson  1703 Bolton St., Baltimore, We bein, Sim Jobson  1703 Bolton St., Baltimore, We bein, Sim Jobson  1704 Burlet 2 Concornor - City or Town, State  205. PLACE AND DATE OF DISPOSITION   Name of Capterley, Cyclerology or City Jobson  21. SIGNATURE FOR FUNEAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY  23. PART I. Enter the diseasese, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, informal Being on State Informal Being Onest and Date of Capterley Being on State Informal Being Onest and Date of Onest					10h Man 11-	ADDRES						
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AARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)  EXAMINER? 1 YES 2 NO  1 YES 2 NO  26. PLACE OF DEATH (Check only one)  EXAMINER? 1 No UNCERTAIN 1 No YES 2 NO  27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 2 See. PLACE OF INJURY AT NUMBER OF INJURY NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO  28e. PLACE OF INJURY AT NO YES 2 NO NO NO YES 3 N	immediate Cause (Finei disease or condition resulting in death)  Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a	UR ODUE TO O	EMIA (OR AS A CON STRU (OR AS A CON	ISEQUENCE OF	F):  F):  OF T	ROPA	ITH	Home, Fi	rostb	urg,	Approximate Interval Between Onset and Da Goday  8 day  8 day
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2 Accident 3 Sulcide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 29e. CERTIFIER (Check only) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner ea stated.	immediate Cause (Fine) disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions.	a  b c d ONTRIBU	DUE TO (DUE TO	COR AS A CON COR A	ISEQUENCE OF DEATH YELACE OF DEAT	F):  F):  FF:  FF:  FR:  In the under  OTHER:	ROPA  WRET  URET  UNION	TH COL ERTAIN	Home, From the as cardisc or res	POSTBO	urg, rest,	Approximats interval Between Onset and Da Go day & day
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D25638 May 30, 199	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST  PART II. Other significant conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST  PART II. Other significant conditions are significant conditions. In the significant condition	D	DUE TO CAL DUE TO CAL	COR AS A CON  STRU  (OR AS A CON  STRU  (OR AS A CON  COR AS A CON  COR AS A CON  DESCRIPTION  (OR AS A CON  COR A	EATH YE LACE OF DEAT  1 DOA  28b. TIMI 1 Norme, farm, 6	F):  CF F):  CF F):  CN Check only OTHER: 4   Nursing E OF URY M 1 street, factory,	WROPA  WROPA  WROPA  WROPA  WROPA  WORK?  YES 2  office  date end place, on, death occur	TH COL ERTAIN	Home, From the as cardisc or residence of the second secon	POSTON AUTOPSY PRIMED? 2 PNO 1 INJURY OCCUPANT OF THE PRIMED PRIM	rest,  Me/d  24b  CCURED  or or Rural F	Approximate interval Betwoonset and Da Goday  STASIS GMONT  WERE AUTOPSY FINDIN AMILABLE PRIOR TO COMPLETION OF CAUSOP DEATHY  1 YES 2 NO  Route Number,

GMD FROS 32. REGISTRAN'S SIGNATURE Lina Sundison handed

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SATURNINA

31. DATE FILED (Month, Day, Year) MAY 3 1 1995

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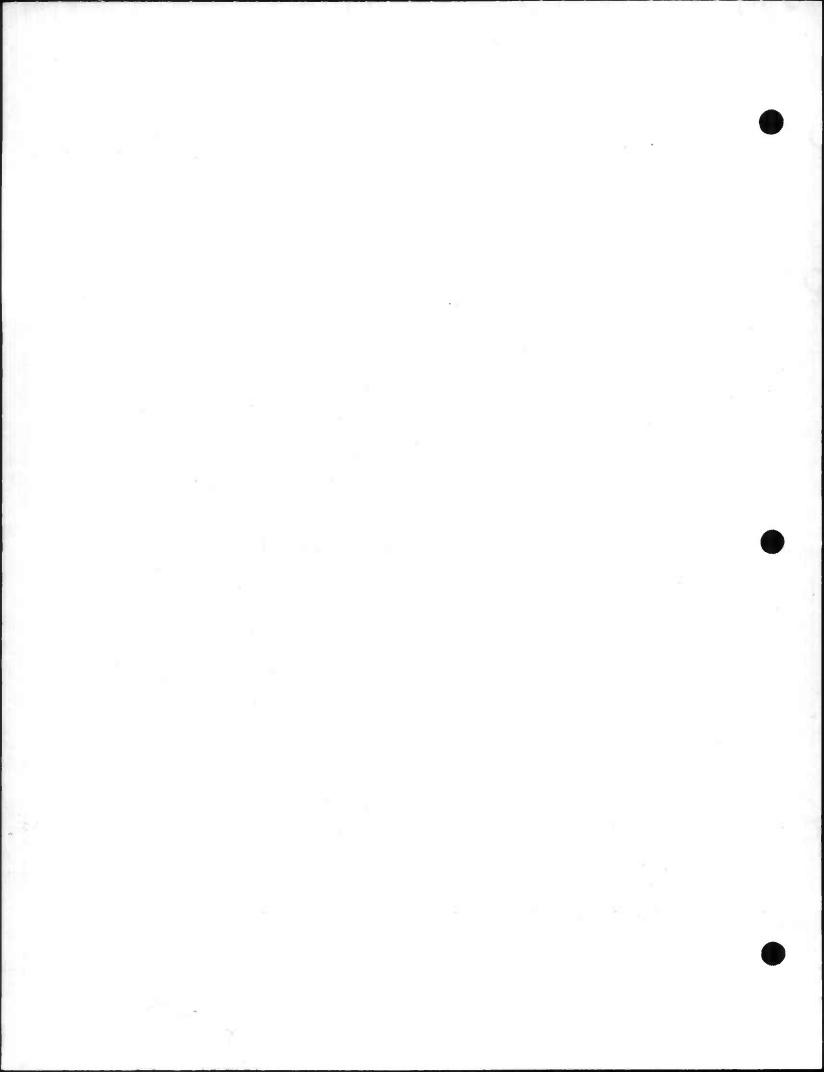
	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMENT	OF I	ALTH	AND I	MENTAL	HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATH	AY	WEAR	3. TIME OF DEATH	
	MYRON	SHPUR							May		1995	YEAR	0705 AM M	
	4. SOCIAL SECURITY NUMBER 187-03-5042	5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 1	_	IF UNDER	24 HRS.	7 DATE OF	BIRTH	1916	a. BIRTH	PLACE (Stote or Foreign	
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, T	OWN OR	LOCATI	ON OF DE	ATH		9c. COU	NTY OF D	EATH	
DIRECTOR	14603 Deerhurst	Terrace	2		Sil	ver	Sp	ring			Мо	ntgo	mery	
	MON MON	tgomery			y, town on Silver			g					10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	14603 Deerhurst	Terrace			-	101. Z	20	906					States	
₩	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		T EVER IN U.S. AR V YES 2 1		If y	es, speci	ty Cuba	OF HISPAN In, Mexical Specify	IIC ORIGIN? n, Puerto Ric	(Specify Yes	or No—	io— 14. RACE — American Indian, Black, White, etc. Specity: White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	Completed)  College (1-4 or 5	(G.	ive kind of Do NOT u	usual occi work done dur se retired.) strati	ng most i		icer		overi		1111111		
6 III	17. FATHER'S NAME (First, Middle, Lest) Trofym Shpur					1		HER'S NAI	ME (First, Mic Wali	dia, Maiden gun				
2	190. INFORMANT'S NAME (Type/Print) Carolyn Sphur		191	1460	ADORESS (S	rhur	Number	or Rural F Terr	ace,	Silve	n, State, Zip	code) ring	, MD 20906	
T T T T T T T T T T T T T T T T T T T	20e. METHOD OF DISPOSITION  1 Displace And Date Of DISPOSITION (Name of Competer) State  20e. LOCATION — City or Town, State Competery, Crametory of other places, Tell Colin Crematory 5/29/95  20e. LOCATION — City or Town, State Competery, Crametory or other places, Tell Colin Crematory 5/29/95  20e. LOCATION — City or Town, State Competery, Crametory or other places, Tell Colin Crematory 5/29/95  20e. LOCATION — City or Town, State Competers, Crametory or other places, Tell Colin Crematory 5/29/95													
examiner must be	21. SIGNATURE/OF PUNERAL SERVICE US	ensee At-A	cella	nd	22. NA H1:	ME AND	Rin	ss of FAC	Fune	ral H e Ave	lome Sil	ver	Spring MD	
and the manual state of the sta	23-PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AL CONSEQUENCE OF)													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
MEDICAL CE	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PROPRIEG?  AMILIABLE PRICA TO COMPLETION OF CAUSE OF DEATH?													
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													
<b>6</b>	1   YES 2 NO   1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)  27. MANNER OF DEATH 1   Netural 5   Pending 2   Accident   Investigation   Netural   Netural   Accident   Investigation   Netural   Netur													
ETED	3 Suicide 6 Could not be determined	28e. PLACE O building,	F INJURY — At horeoff, (Specify)	ne, farm, :	street, factory.	office			28f. LOCATI City or	ON (Street e Town, Stete)	nd Number	or Rural R	oute Number,	
COMPLETE	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) end manner as stated.  2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end piace, and due to the cause(s) end manner as stated.													
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	zuli	'u I	V.	>	21	Pc. LICE	NSE NUM	BER / -	2	29d. DATE	SIGNED	(Month, Day, Year)	
<sup>=</sup>   유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED ONLY		-			-	(0	4			110	1171	

Dr. Ira Tauber10301 Georgia Avenue, Ste304; Silver Spring, MD

31. DATE FILED (MONIN, Day, 1964)

MAY 30 1995

Julia Akudisa Carlell



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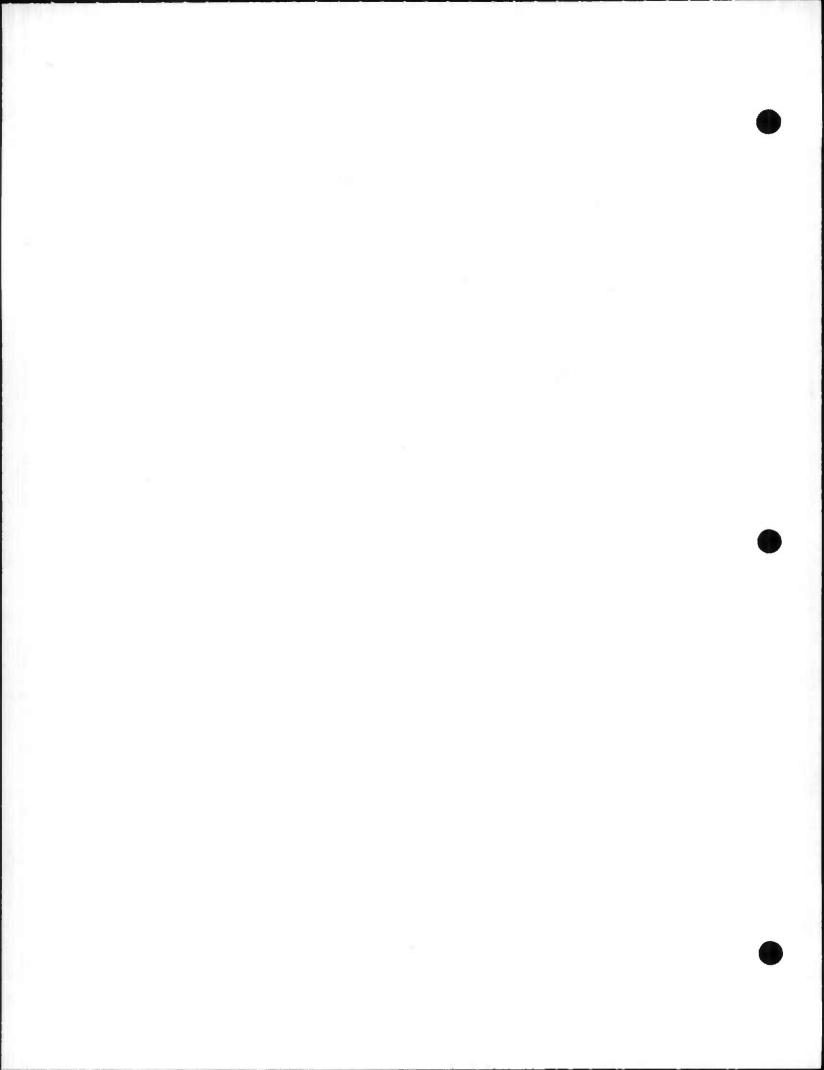
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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		1. DECEDENT'S NAME (First, Middle, Last)  MELVIN  L	SHIPE	CD							DAY	YEAR 3.	TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER	SR. (In yrs. las	t birthday)	IF UNDER	t YEAR	IF UNDER :	24 HRS.	MAY 27 1995 7. DATE OF BIRTH 8. BIF			3:20 A ACE (State or Foreign	on M	
Pin		579-09-2741	MONTHS	DAYS	HOURS	OCT. 17,1914 WEST VIRG					1			
, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give street and number)  8701 W00DFIELD COURT  99. CITY, TOWN OR LOCATION OF DEATH GAITHERS BURG  90. COUNTY OF DEATH MONTGOMER'												
physician. burial-transit permit. Pages 1, 2,	DIRECTOR	10a. STATE 10b. COUNTY MARYLAND MONTGO				THERS							d. INSIDE CITY LIMITS?	
nsit permi	FUNERAL	8701 WOODFIELD CO	DURT				10	of. ZIP CODE	2088	82		TED ST	T COUNTRY?	
fing physician.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR C 1944-1945	IN U.S. ARI 2 NO DATES	MED	11	yes, sp	CENDENT OF Pecify Cuben	n, Mexican	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	e or No—	Specify:	American Indien, hite, etc.	
r attending use as the	ED	15. DECEDENT'S EDUC (Specify only highest grade	ATION	16a. DE	CEDENT'S	USUAL OC	CUPATI	ON		16b. KIND OF BU	ISINESS/INC		ITE	
spital or	COMPLET	Elementacy/Secondary (0-12)	College (1-4 or 5+)	life.	NDSC/	retired.)	uring mo	ost of working	7	LANDS	SCAPI	NG		
at on the	BE CO	17. FATHER'S NAME (First, Middle, Lest) SOLY SHIPE						18. MOTH		RIGGLEM				
y be retained to hage 5 should be notified	TO .	190. INFORMANT'S NAME (Type/Print) MABEL LOUISE SH	[PE	8	701 V	ADDRESS 100DF	(Street o	end Number of D COU	or Rural Ro JRT	GAITHERS			20882	
rector, p		20e/METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State		AWN O	EMET	ERY			30/95 ROC		City or Town, LE,MAR		
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND												
y filled in by the trion, or remova		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.  Approximats interval Between Onset and Desti												veen
ted within z completely fial, cremation: event, th		disease or condition resulting in death)  Due to (or as a consequence of):												
and com burial, c	Z	- PARKINSON DISEASE												
icate be execut physician and on the prior to buri	ATIO	Sequentially list conditions, If any, leading to immediate cause. Editor UNDERLYING												
e death certificate he attending phys Mental Hygiene pi Ijury, or other i	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST												
		PART II. Other significent conditions	contributing to deeth t	out not re	sulting in	the unc	lerlyin	g cause gl	lven in P	Part I, 24s. WAS AN	AUTOPSY	24b. WE	RE AUTOPSY FINDI	INGS
that ed b th ar	MEDICAL	Organic brain sy	ndrome Di	1sph.	4914					PERFO	RMED?	CO	MPLETION OF CAUS DEATH?	
requires been sign of Healt											YES 2 NO			
N: The law ficate has bo State Dept.	AN	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE C		E OF DEAT				RTAIN					
SIAN: Therificate he State	PHYSICIAN:	EXAMINER?  1  YES 2  NO	HOSPITAL:			OTHER			idence 6	Other (Specify)				
NG PHYSICI frer this cer eath with the	Y PHY	27. MANNER OF DEATH 1 Natural 5 ☐ Pending	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME INJU	OF :	Bc. INJ	JURY AT DRK?		28d. DESCRIBE HOW	NJURY OCC	URED		
OR ATTENDING PHYSICIAN: The law requirest the this certificate has been hours after death with the State Dept. of tem 28 is marked, or item 23 sho	TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, or building, etc. (Specify)											Number,	
로 보고 =	COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated.  2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(a) and manner es stated.											d.	
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: If	BE C	25s. SIGNATURE AND TITLE OF CERTIFIER					I ex ligation in the second				29d. DATE SIGNED (Month, Day, Year)			
₽ ₽ ₽ <b>₩</b>	5	30. NAME AND ADDRESS OF PEASON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						D18726   May 27, 1995  MD. 20832						
4)														
		31. DATE FILED (Month, Day, Year)  MAY 3.0 1005	32. REGISTRAR'S SIGN		11	/								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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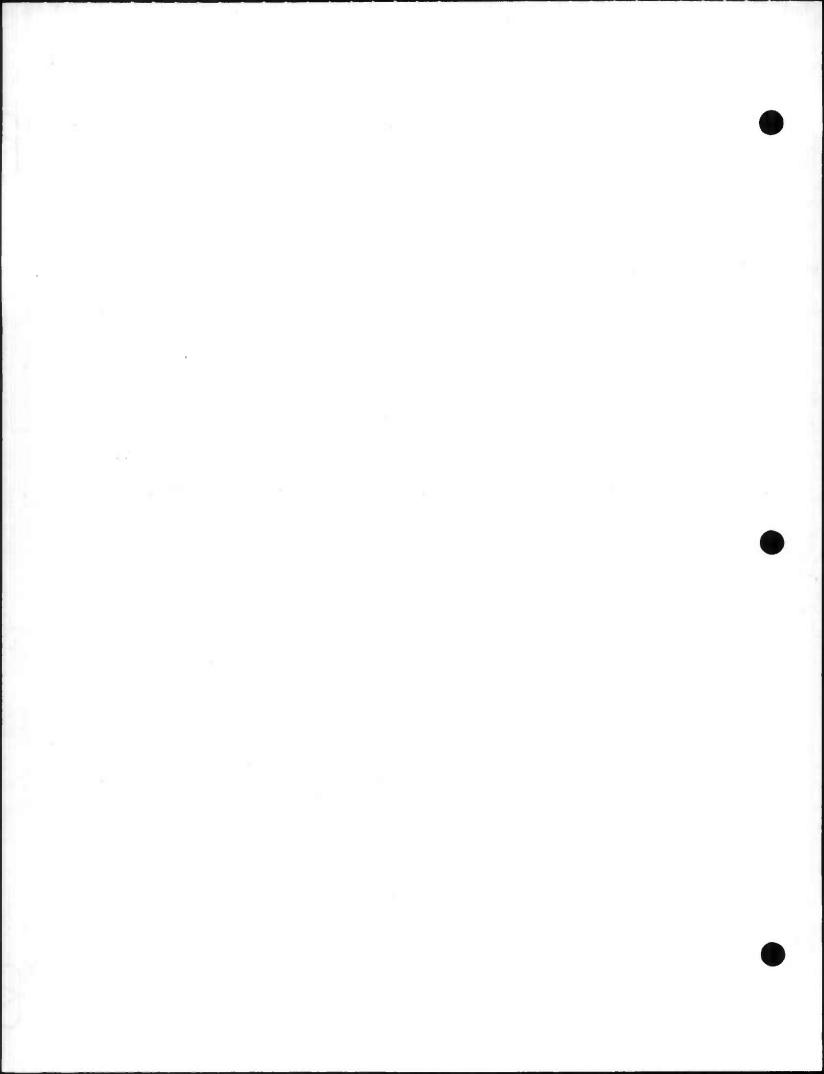
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	<b>MENTAL HYGIENE</b>
CERTIFICATE OF DEATH	REG NO

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF H	EALTH AND	MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)	James J				2. DATE OF DEATH MONTH MAY 2		3. TIME OF DEATN 8:55 A M					
	4. SOCIAL SECURITY NUMBER 036-03-9093	1X M 2 D F 80		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	NPLACE (State or Foreign							
TOR	9a. FACILITY NAME (If not institution, give structured of the stru		91	Chevy	Chase	EATH	9c. COUNTY OF						
DIRECTOR	10a. STATE 10b. COUNTY	ontgomery	10c. CITY, T	Chevy				10d. INSIDE CITY LIMITS?  1 X YES 2 NO					
FUNERAL	100. STREET AND NUMBER 4501 Cumberland A				ZIP CODE		20.6	WHAT COUNTRY?					
UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	I U.S. ARMED	13. WAS DECI		20815 NIC ORIGIN? (Specify Ye		S . A .					
ВУ	1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 2 YES IF YES, GIVE WAR OR DA Korea	2 NO	If yes, spe	cify Cuban, Mexice	n, Puerto Rican, etc.)	Blad	ck, White, etc.					
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	16a, DECEOENT'S USI (Give kind al work life. Do NOT use re	done during mos	N at of working		SINESS/INDUSTRY						
PM P	17. FATHER'S NAME (First, Middle, Last)	5 +	Dentist		te MOTHERIE NA	Dentist							
BE C	Joseph Samajed	en				es Skawien							
10 B	19a, INFORMANT'S NAME (Type/Print)					Route Number, City or Tox	vn, State, Zip Code)						
	Corrine P. Steven				nd Ave.	Chevy Cha		20815					
	1 1 Burial 2 Cremation 3 Remove	val from State com	PLACEAND DATE OF D etery, crematory or other ate of Hea	place)		5/27 Sil	ver Spri						
	21. SIGNATURE OF JUNERAL SERVICE LICE	NSEE /	ice of nea	22. NAME AN	D ADDRESS OF FA	CILITY Joseph	Gawler's	Sons					
	Lemm	Senes	utus.	5130 W	I Ave. N	W Washing	gton, D.C	20016					
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	implications that caused ist only one ceuse on e	the death. Do not sch line.	enter the mod	se of dying, auc	h as cardiac or reap	fratory arrest,	Approximate Interval Batween					
	IMMEDIATE CAUSE (Finel disease or condition	acti -	7	( -	7 ~			Onset and Death					
ŀ	resulting in death)  a. ASTO CUTOMO OF The Real N  DUE TO (OR AS A CONSEQUENCE OF):												
N	Sequentially list conditions b.												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):										
Ē	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF):										
H	resulting in deeth) LAST												
귛	PART II. Other aignificent conditions	contributing to deeth be	ut not resulting in t	he underlying	cause given in	Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS					
PHYSICIAN: MEDIC	STrokes					1 YES :		COMPLETION OF CAUSE OF DEATH?					
W	DID TOBACCO USE CONTRI	IRLITE TO CALISE O	E DEATH YES		LINICEDTAIN			1 YE5 2 NO					
NAI	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (		ONCERIAII	101							
YSIG	1 □ YES 2 K NO	HOSPITAL: 1 Inputient 2 ER/Output		THER:  Nursing Nome	5 Residence	6 Other (Specify)							
ву Рн	27. MANNER OF DEATN  1  Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WOR		28d. DESCRIBE HOW	NJURY OCCURED						
	3 Suicide a Could not be determined	end Number or Rural	Route Number,										
COMPLETED		AN: To the best of my knowle On the basis of examination						a) and manner as stated,					
BE C	THE TURE AND TITLE OF CERTIFIER	-11 -			29c. LICENSE NUN			(Month, Day, Year)					
TO B	M · / I	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Tono Date	· ·	DIL	888	> 5	25-95					
	Russell M. Tilley,		4701 Mas		. N. W.	Washingto	on, D. C.	20016					
	31. DATE FILEO (MORIH, Day, Year) MAY 31 1995	32. REGISTRAR'S SIGNA	TURE										
	mui 9T 1332	Julia Davelson	Nevdall.										



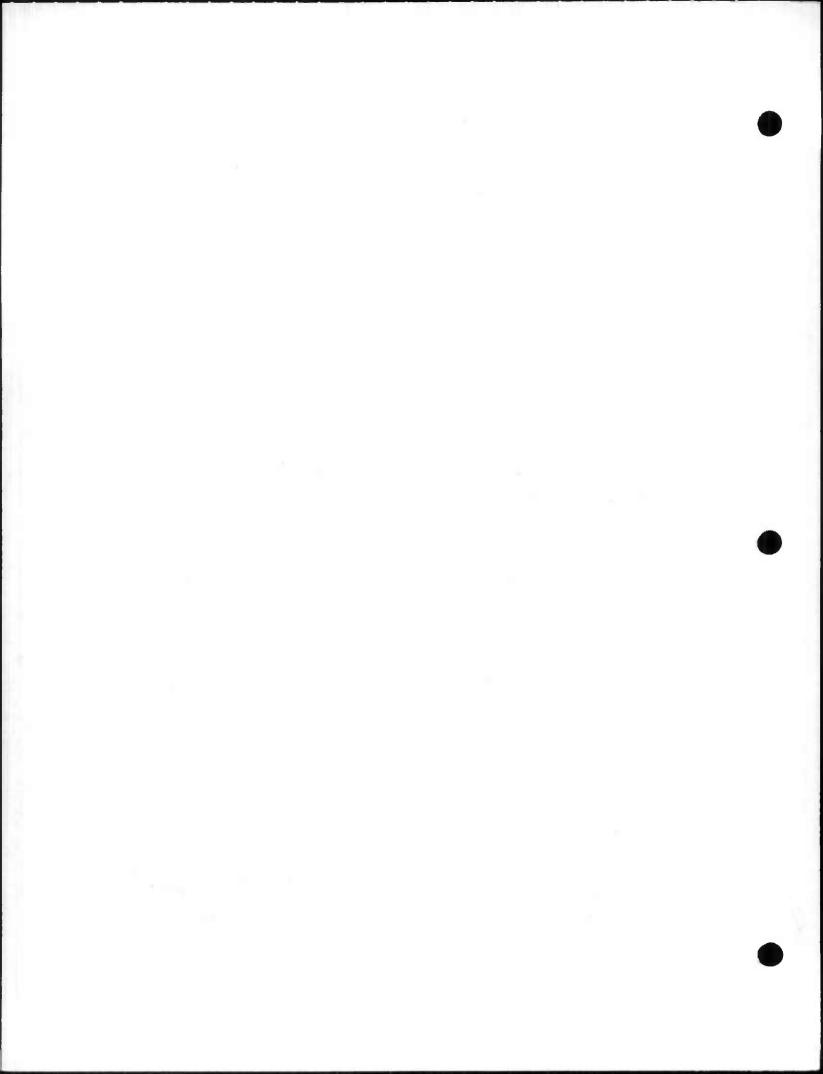
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to the float head to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	OF HE	ALTH AN	D ME	NTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)								DATE OF DEATH		995	3. TIME OF DEATH
	Evelyn	Ruth Sandler						1	Yay 24	10 A. M		
	4. SOCIAL SECURITY NUMBER 577–42–9106	1 □ M 2 🔀 F	6. AGE (In yrs. lest	VRS.	IF UNDER		IF UNDER 24 HR HOURS MIN	s. 7. N	DATE OF BIRTH (Month, Day, Year) OV 26 19(	09	New	PLACE (State or Foreign Y) Jersey
ac.	9a. FACILITY NAME (If not institution, give a						LOCATION OF	F DEATH			NTY OF D	
DIRECTOR	Potomac Valley Nu	irsing Ho	me		ROC	ckvil	Te			MOI	ntgor	mery
REC	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCATIO	ON					10d. INSIDE CITY
		jomery		Roo	kvi]							1 2 YES 2 NO
RA	100. STREET AND NUMBER 2893 Glenora Lane					1000	0850			10,0	IZEN OF Y	VHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARA	4ED	13			PANIC	RIGIN? (Specify Yes	US	44 DAC	A control to Mile
F	1 Never Married 2 Married	FORCES? 1	YES 2 N	0		If yes, spec	ify Cuben, Ma:	xican, Pu	erto Rican, atc.)	or No-	Black Speci	— American Indian, c. White, atc.
Э ВУ	3√ Widowed 4 □ Divorced				.		X NO SP	oury.			Speci	white
Ë	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	(Gh	re kind of a	work done	CCUPATION during most			16b. KIND OF BUS	INESS/INC	DUSTRY	
F.	Elementary/Secondary (0-12)	College (1-4 or 5+)	'	Do NOT U					Reta	. 4 1		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			TOCE	- L		18. MOTHER'S	NAME (	First, Middle, Maiden S			
BE C	Unknown	Dlugash							Unknown	,		
10 B	19a. INFORMANT'S NAME (Type/Print)						Number or Ru	ral Route	Number, City or Town			
-	Jerome J. Sandler		28	393 (	lenc	ora L	ane R	lock	ville MD	2085	50	
	20a. METHOD OF DISPOSITION  1-7 Burlal 2 Cremation 3 Remains	oval from State	20b. PLACE A cemetery, cren	natory or o	ther place)					CATION —		,
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE US	ENSEE	IKing I	avio	22	NAME AND	ADDRESS OF	EACH IT	5-26 Fali			n VA
	·60 01	0			Ed	dward	Sage1	. Fu	neral Di			
	23. PART I. Enter the diseesea, or c	amplications that	annead the de-	41. 7			ockvi1					1D 20852
	shock, or heart fellure.	List only one caus	e on each line.	nn. Do i	iot enter	tne mod	or dying, a	uch ea	cerdlec or reapir	atory an	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	50	:PSIS									Onset and Death
	resulting in death)	DUE TO (	OR AS A CONSEO	UENCE O								> DAYS
Z	STAPH. AURIUS CYSTITIS AND VAGINITIS											
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (	OR AS A CONSEC	UENCE O	F):							
임	CAUSE (Disease or Injury that initiated events	DUE TO (	OR AS A CONSECU	UENCE O								
IH	resulting in deeth) LAST	i										
	PART II. Other aignificent condition	s contributing to	feeth but not re	eultino.	in the un	derlylpe	sauce alven	In Bort	J. 24a, WAS AN A	LI TODON	Lan	
CAL	MULTI-			DE	ME	NT	A	in Part	PERFORI	HED?	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC/	7.10.61.7	2 10 1 / 11			7	10 /			1 TYES 2	XNO		OF DEATH?
2	DID TOBACCO USE CONTR	RIBUTE TO CAL	JSE OF DEAT	H YE	s 🗆 I	NO IN	UNCERTA	AIN [	7			1 YES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE		H (Check	only one)						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN   25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2     NO   NO    10   No   NO   NO    26. PLACE OF DEATH (Check only one)  27. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO   NO    26. PLACE OF DEATH (Check only one)  27. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   NO   NO   NO    26. PLACE OF DEATH   OF DEATH    27. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. DATE OF INJURY 28. DATE OF INJURY    28. DATE O												
ву Рн	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF I (Month, De	NJURY y, Year)	26b. TIM INJ	E OF \ URY	28c. INJUI WORK 1 YE		280	. DESCRIBE HOW IN	JURY OC	CURED	
									or Rural R	oute Number,		
COMPLETED		CIAN: To the best of n										
	2 MEDICAL EXAMINE		minetion and/or in	rvestigatio	n, in my o				data and place, and			
TO BE	Mr cen	win 971	tending	the	sicio	m	) / f	O F	4	29d, DAT	SIGNED 2	(Morny, Day, Year) 4/95
	30. NAME AND ADDRESS OF PERSON WHO	M'D.	/	27) (Type,		205	ER	D, 1	Rockv	(LLE	MI	20852
	31. DATE FILED (MONTH, Day, Year) MAY 31 1995	32. REGISTRAR						/		7		
	= 1000	0	The state of the s	4		<del></del>		_	-			DIAME 18 Pay 1/80

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Flossie Sigmon Lail May 28. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR DAYS HOURS 1 M 2 D F VRS. 579-44-3416 Sept. 27, 1910 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Shady Grove Hospital Rockville 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery permit. Kensington FUNERAL 10f. ZIP CODE and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit or burial-transit. 3113 Jennings Road 20895 Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 1 YES 2X NO Specify: 3 🕅 Widowed 4 🗌 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) Registered Nurse 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ħ John BE Georgianna notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy S. Butchart 33 Chantilly Court ě 20s. METHOD OF DISPOSITION
1 ☑ Burlai 2 ☐ Cremellon 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE must 1 分 Burlel 2 ☐ Cremellon 3 ☐ H 4 ☐ Donation 5 ☐ Other (Specify) \_ Fort Lincoln Cemetery 6/1/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACULTY
Francis J. Collins Funeral Home, Inc. hours after death. cancel 500 University Blvd., W. Sil.Spr., MD 20901 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. **IMMEDIATE CAUSE (Finel** the disease or condition executed within 24 Pneumonia resulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL by th any Hypothroidism Health a Electrolyte Imbalance been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖘 UNCERTAIN 🗆 PHYSICIAN: OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate h HOSPITAL: OTHER: 1 YES 2 KNO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? 1X Natural 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide COMPLETED 6 Could not be 4 Homicide 28 29a. CERTIFIER 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL within 72 h = 2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 50 W.

Jalia Dander Randall

Trehan, M.D

JUN 01 1995

31. DATE FILED (Month, Day, Year)

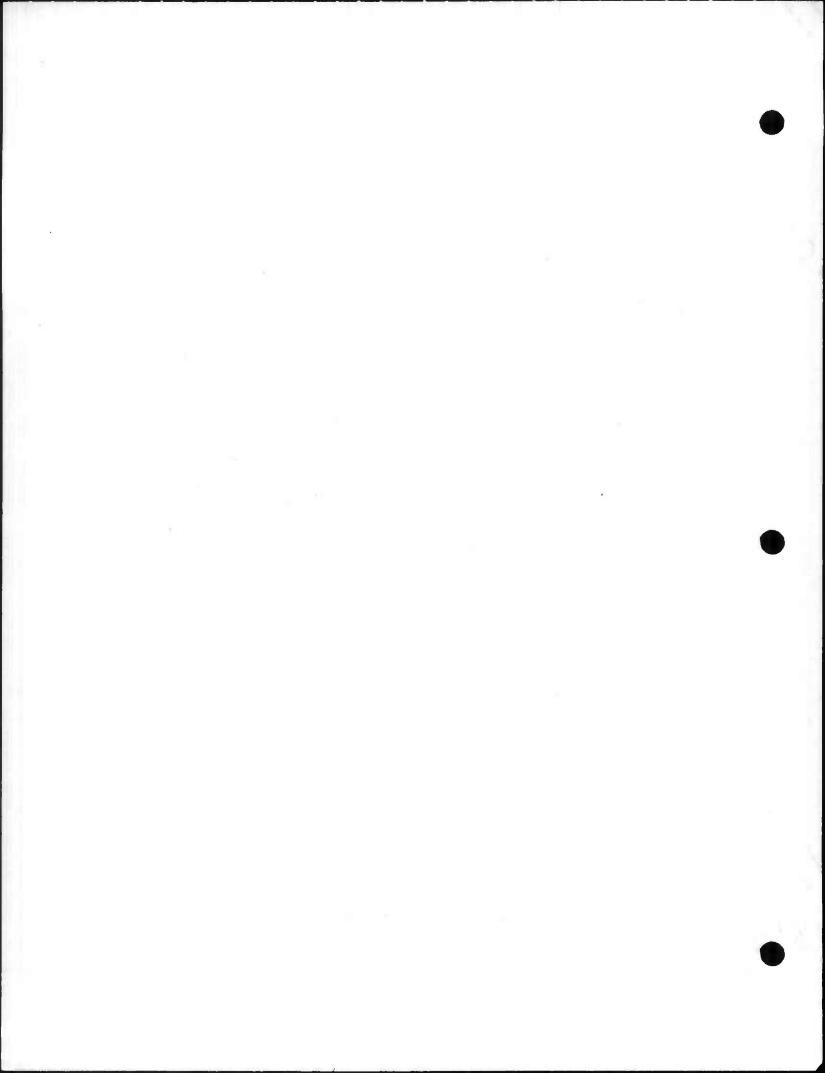
CERTIFICATE OF DEATH

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Edmonston Drive #401 Rockville Maryland

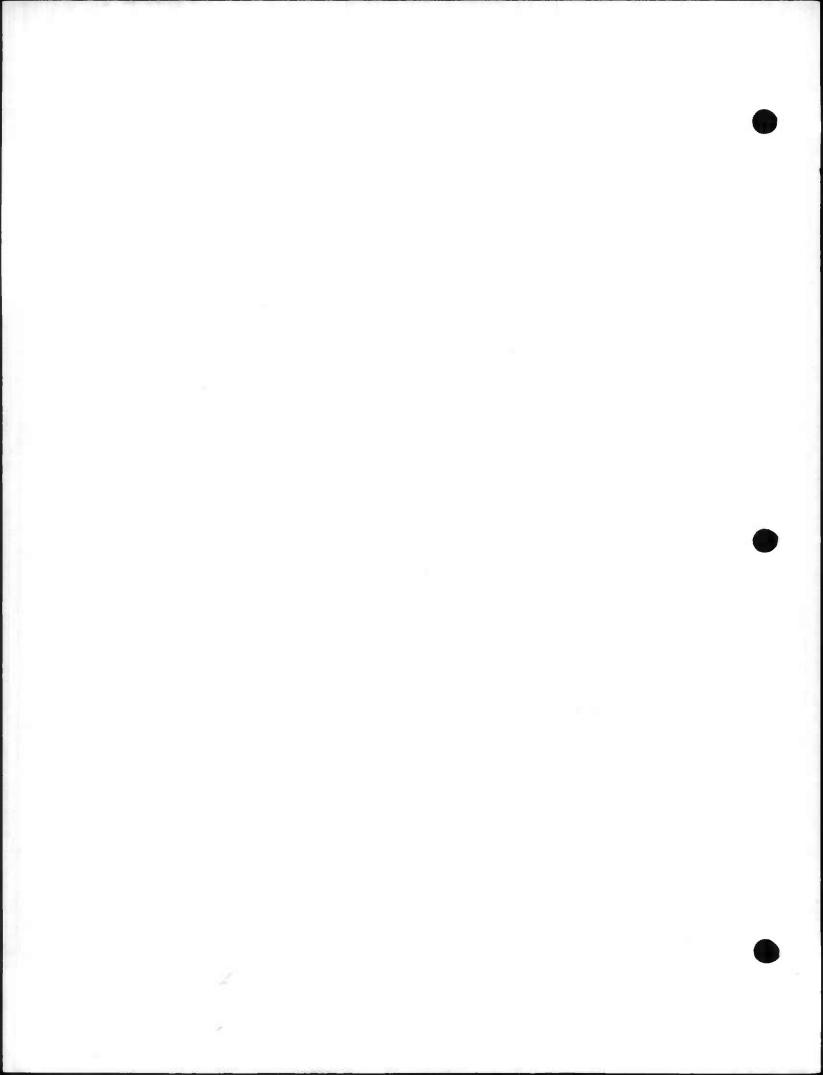
FOR STATE REGISTRAR

95 18663 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH 1995 0530 8. BIRTHPLACE (State or Foreign Country) North Carolina Montgomery 10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? 14. RACE - American Indian, Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Medical Brown Rockville, Maryland 20850 20c. LOCATION - City or Town, State Brentwood, Maryland Approximata Onset and Death 4 Days 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) May 28 .1995



		1. DECEDENT'S NAME (First, Middle, Last)					
		ROY EMANUEL S	MAI				
		4. SOCIAL SECURITY NUMBER	5. S				
		107-54-6442					
pino	1	9e. FACILITY NAME (If not institution, give st	1 []				
& &	Œ	National Institut					
1, 2,	1 6	RESIDENCE OF DECEDENT	-				
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020 physician. burial-transit permit. Pages 1, 2, 3 should	BY FUNERAL DIRECTOR	New York Monroe					
E-	AL AL	10e. STREET AND NUMBER					
nsit .	E E	125 St. Paul Stre	еt				
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Phys buri	7	1 Never Merried 2 Married	II.				
5-0 Oding	8	3 Wildowed 4 X Divorced					
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21 12 or 12	Ш	Elementary/Secondary (0-12)	Col				
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AN the hor detach	8	17. FATHER'S NAME (First, Middle, Last)	_				
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AF		19s. INFORMANT'S NAME (Type/Print)					
, IV be re be 5 be 5	F	Horace Watkins					
TA Dag		20e. METHOD OF DISPOSITION 1   X Burlel   2	ment de				
O Per 6		4 Donation 5 Other (Specify)					
TIN Pag		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSE				
BALTIMORE, MARYLAND 21215-0020 its death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burtal wal.		> Harry U. Y	ho				
B. after y the noval.	- 1	23. PART I. Enter the dispesses, or c	omn				
RECORDS, P.O. BOX 68760  BALTIMORE, MARYLAND 21215-0020  equires that the death certificate be executed with thours after death. Page 6 may be retained by the hospital or attending physician en signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trand Hospiene prior to burial, cremation, or removal.  hows any injury, or other traumatic event, the medical examiner must be notified at once.		shock, or hasrt fallure. I	List o				
filler, ion,	i II	IMMEDIATE CAUSE (Final disease or condition					
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RECORDS, P.O. BOX 68760, requires that the death certificate be executed with een signed by the attending physician and complete of Health and Mental Hyglene prior to burial, cremshows any injury, or other traumattic event	MEDICAL CERTIFICATION	PART II. Other algolificant conditions	s cor				
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ING ING I	B	2 Accident Investigation	-				
ATTENDII CTOR: A after de		3 Suicide 8 Could not be 4 Homicide determined					
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DIVI SPITAL DR AT VERAL DIRECT HIN 72 hours:	OMPLETE	29e. CERTIFIER	_				
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4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In	yrs. last birthday)	IF UNDEF	1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIO	TM	I a pin	6:40 PM
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National In			alth			ethe		AIN		county of	
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New York	Monroe				ester						LIMITS? 1 XYES 2 NO
125 St. Pau	1 Stre	et					21P CODE 4620				States
11. MARITAL STATUS 1 Never Merried 2 3 Vidowed 4 X Divo		12. WAS DECEOEN FORCES? 1 IF YES, GIVE W	YES	2 X NO	1	If yes, spe	ENDENT OF HISPAN city Cuban, Mexice 2 [X] NO Specifi	n, Puerto Rican, e	Ify Yee or I	No — 14. RAG Bla	CE — American Indian, ck, White, atc.
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19s. INFORMANT'S NAME (7				19b. MAILING	ADDRES	S (Street or	Bernic				
Horace Watk	Horace Watkins 324 New York Ave., #10, Brooklyn, N.Y. 11213										
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shock, or h											
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PART II. Other algnifics	ent condition	s contributing to	death bu	t not resulting	In the ur	ndariying	cause given in		MAS AN AUT ERFORMED YES 2	0?	ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
DID TOBACCO		ONTRIBUTE	TO C	CAUSE OF	DEAT						
EXAMINER?	O MEGICAL	HOSPITAL:	ER/Outpat	Nant 3 DOA	OTHE	R:	S ☐ Rasidence		4.1		
27. MANNER OF OEATH  1 Natural 5	Pending Investigation	28a. OATE OF (Month, D	INJURY	28b. TIM		28c. INJU	JRY AT	26d. DESCRIBE		RY OCCURED	
3 Suicide 8	Could not be determined	28a. PLACE O building,	F INJURY - atc. (Specifi	At home, farm,	street, fec	tory, office		281. LOCATION ( City or Town	Street and f	Number or Rural	Route Number,
		CtAN: To the best of R: On the bests of e									(e) and manner se stated.
10 A	OF CENTIFIER						29c LICENSE NUI	MBER		d. DATE SIGNE	
30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAUS	SE OF DEAT				3 -	· 1		1,7	- / ( )
31. DATE FILEO (Month, Day,	(49( Year)	32. REGISTRA	R'S SIGNA	TURE	OCKV	ILLE	PIKE BI	ETHESDA,	MAR	YLAND	20892
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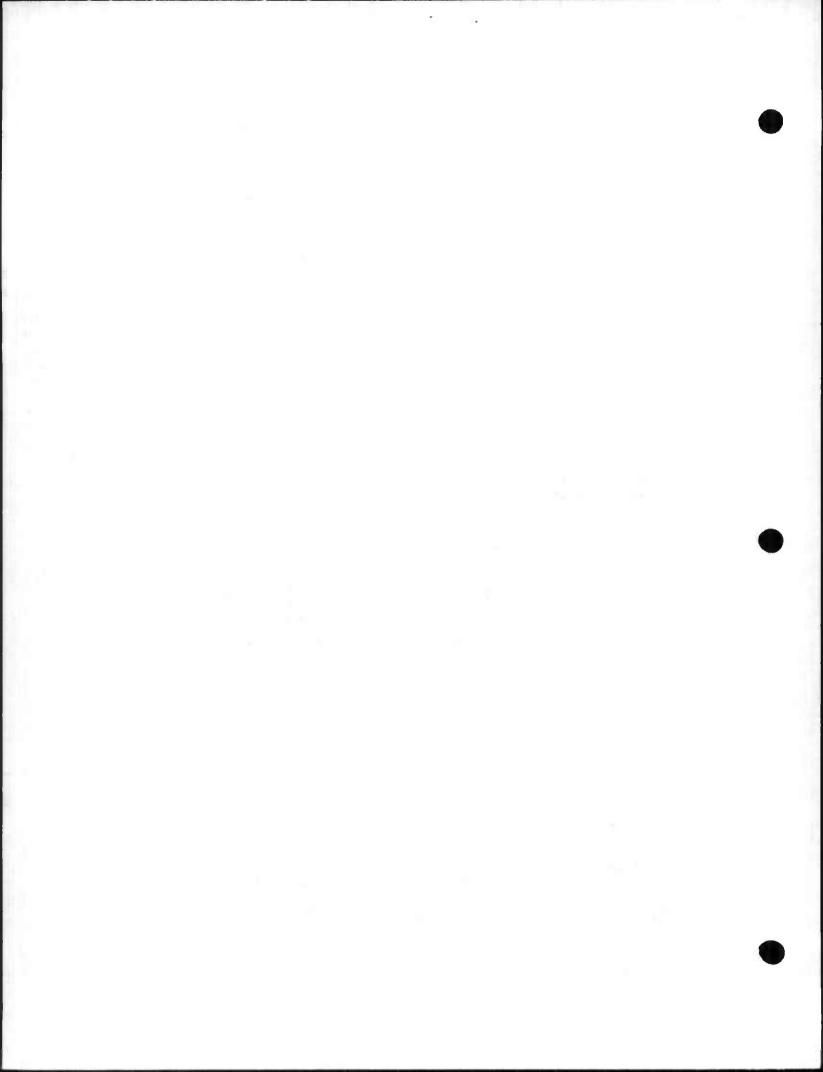
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) all

204 22. REGISTRAY'S SIGNATURE

95 18665 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Inc JUNE 4:35 FM 25 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 TF 81 535 - 12 - 9047 July 4,1913 Washington 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington Snohomish Everett 1 X YES 2 NO FUNERAL 104 STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5314 Beverly Lane 98203 USA 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Pu 1 YES 2 X NO Specify: 1 Never Married 2 Married ВҰ 3 🔀 Widowed 4 🗌 Divorced Specify White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Coflege (1-4 or 5+) 3 Years Clerk County Government once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Freeman K. Sigfusson Josebina Josephson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 David Sander 6900 Whitkan Place, Aberdeen, Washington 98520 Pe 20a. METHOD OF DISPOSITION
1 

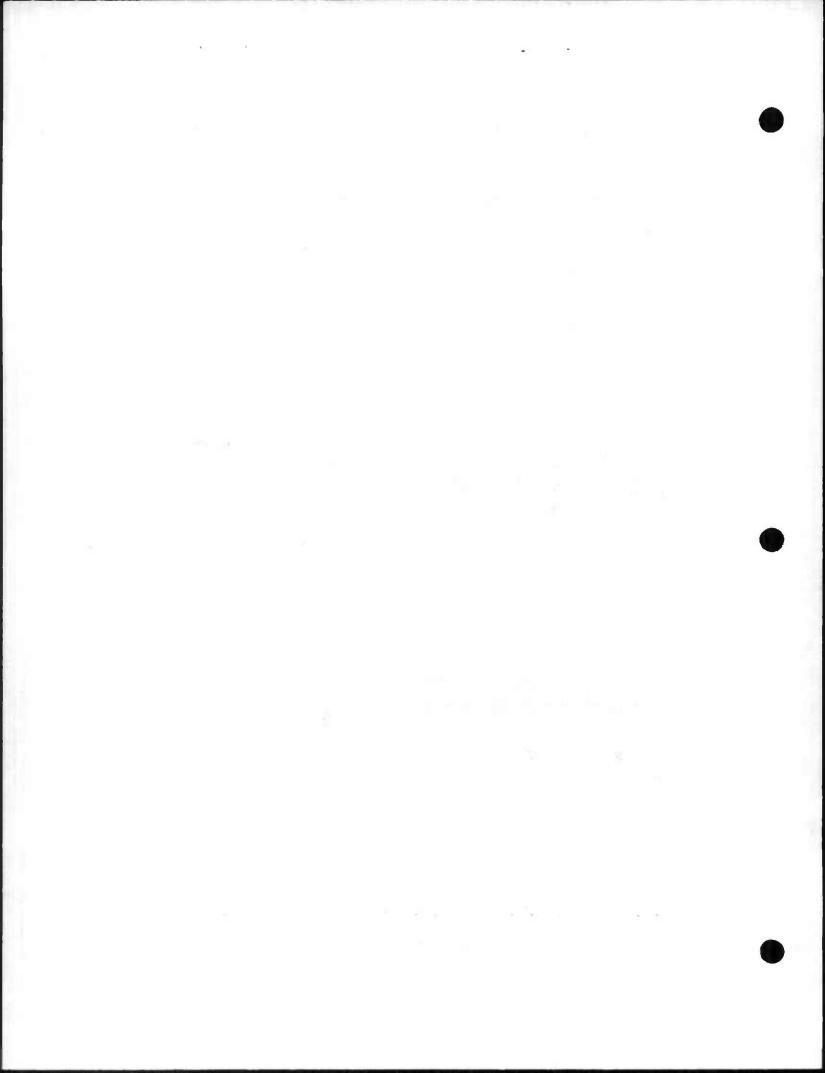
Burial 2 Cremetion 3 
Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must metery, crematory or other plece)
Bav View Cemetery 4 Donation 5 Other (Specify) 6/9 Bellingham, Washington examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 medical 23. PART i. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Fine) Onset and Death the disease or condition resulting in death) ar diogenic traumatic event, QUE TO (OR ASIA CONSEQUENCE OF month 01 CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events reaulting in death) LAST 6 may, PART ii. Other significent conditions contributing to deem but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any TYES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN TO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Tem I HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO ng Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 90 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 Hell 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURS AND TIME OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (FIRE	MOST METONS	Š		OLITTI	IOAII	_ 01	DLA		2, DATE OF MONTH		MY	YEAR	3. TIME OF DEATH
	FRANCIS  4. SOCIAL SECURITY NUMBER		ND SHR	6. AGE (In pro	: lear birmday)	IF UNDER	I YEAR	# UNDER	24 HRS.	T DATE OF	23,	199		L1:00 p
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~	the FACILITY NAME (If not inst	Muttor, give	street and number)			9h. CITY	, TOWN	OR LOCATI	ON OF DE			Se, COU	NTY OF DE	EATH
DIRECTOR	DEER'S HE	AD C	ENTER			S	ALI	SBUR	Y			WI	COM	ICO
IRE	MARYLAND	TUT C	OMICO		(1)983-0	SALI:								104. INSIDE CITY LIMITE?
	10s. STREET AND NUMBER	WIC	OFFICO			SALL		I. ZIP COD	e .			T May CITY	IZEN OF W	1 YES 2 ☐ HI
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	21. SIGNATURE OF FUNERAL	SERVICE U	CENTREE	111.		22 Z1	NAME A	R FU	NERA	L HOME	.P.O	, BOX	3171	0
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CERTIFICATION	Sequentially list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in death) LAST	ig		(OR AS A CON										
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and least. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	. HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Amos Garfi	eld Sar	npson			June (		995 14:36 M
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	216-13-0439	1⊠ M 2 □ F 58	3 YAS.			Feb.12,		Maryland
œ	9e. FACILITY NAME (If not institution, give str				R LOCATION OF DE	EATH	1	Y OF DEATH
DIRECTOR	Dorchester Ger	ieral Hosp	ital	Cambri	dge		Dor	chester
REC	10s. STATE 10b. COUNTY			Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
		nester	L	<u>inkwood</u>				1. YES 2 NO
3AL	104. STREET AND NUMBER			101	ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	Box 157	12. WAS DECEDENT EVER IN			21613			SA
	1 Never Married 2 Married	FORCES? 1 TYES	2 NO	If yes, spi	city Cuben, Maxica	NIC ORIGIN? (Specify Ye n, Puarto Rican, atc.)	s or No— 1	4. RACE — American Indien, Black, Whita, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 L YES	2 NO Specifi	À.		Specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)		USUAL OCCUPATIO		16b. KIND OF BU	SINESS/INDUS	
	Elementary/Secondary (0-12)	College (t-4 or 5+)	life. Do NOT us	e retired.)				4
MP	2. 17. FATHER'S NAME (First, Middle, Last)		Farm	Hand		Farm		
						ME (First, Middle, Maiden		
BE	Linwood Sams	oson	19b. MAILING	ADDRESS /Street #		e Wonqus Route Number, City or Tow		Parint
2	Pauline Davis	-				enna Mary		
	20s. METHOD OF DISPOSITION	20b	PLACE AND DATE	F DISPOSITION /No.	nie of	DATE 20c LC		ty or Town, State
	©C Burlel 2 ☐ Cremation 3 ☐ Ramo 4 ☐ Donation 6 ☐ Other (Specify)	Sa Sa	etery, crematory of or alem Ch	urch Ce	metery	6/6 Sa	lem,M	aryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE 01		22. NAME AN	D ADDRESS OF FA	CILITY		
	Xanelle	Cix	ewing	Henry	Funer	al Home	ambri	dge,Maryland
	23. PART I. Ther the diseases, or conhock, or heart failura. L	omplications that caused	the death. o r	ot enter tha mo	da of dying, auc	h as cardiac or resp	iratory arres	st, Approximate
	IMMEDIATE CAUSE (Final	ist only bria cause bri at	ach ima.					intarval Between Onset and Death
	disease or condition resulting in daeth)  Gastro-intestinal bleeding							1 year
	Esophageal carcinoma							
o	Sequantially list conditions, if any, leading to immediate		CONSEDUENCE OF					1 year
8	cause. Entar UNDERLYING							1
E	CAUSE (Disease or injury that initiated evants	DUE TO (OR AS A	CONSEQUENCE OF	7):				
CERTIFICATION	resulting in death) LAST							
ALC	PART II. Other aignificant conditions	contributing to death b	ut not reaulting	n the undarlying	cauae given in			24b. WERE AUTOPSY FINDINGS
20						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME								OF DEATH?
ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S NO D	UNCERTAIN	V 🗆		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:				
1YS	1 VES 2 NO	Inpatient 2 ER/Outp	etlant 3 DOA	4 - Nursing Home		6 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	INJ		RK?	26d. DESCRIBE HOW I	NJURY OCCU	RED
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY	— At home, ferm, s			261. LOCATION (Street	and Number or	Rural Route Number,
Ë	4 Homicide determined	building, atc. (Spec	ny)			City or Town, State)		
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edge, death occurre	d at the time, date	and place, and due	to the cause(s) and me	nner es stated	
MO	1-1							ceuse(s) and manner as stated.
w II	294 SCHATURE AND TITLE OF CERTIFIER	11 m			29c. LICENSE NUN	IBER	29d. DATE S	SIGNED (Month), Day, Year)
00	1016 and	7 11.11			D464	34	100	101/95
5	James McAnulty,	M.D.	300 Aur	ora Stre	et Cam	bridge, MI	216	13
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	ATURE					
	JUN 0 6 1995	Julia dhuulean	Kardall					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1	-	STATE REGISTR	AFI
	_	FOEDENITIO	

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR				CAIL			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	OBBY GE	ME CO	rerl:	TNC		١.	DATE OF DEATH	y 10	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER						_	May 19,	19		2:00 P. M
	220-32-2435	5. SEX 6.	AGE (In yrs. less		IF UNDER 1 YE			DATE OF BIRTH (Morith, Day, Year)		Country	
			37	YRS.				July 22,	1937		aryland
<u>م</u> ا	9a. FACILITY NAME (If not institution, give s					N OR LOCATION OF			100	NTY OF DI	EATH
DIRECTOR	Home - 8 Standard	a Avenue		Crisfield, MD Somerset						rset	
낊	10a. STATE 10b. COUNTY	Y		10c. CITY	, TOWN OR LO	CATION					10d. INSIDE CITY
등	Maryland	Somerset	t			Crisfield	1				LIMITS?
	10e. STREET AND NUMBER					10f. ZIP CODE		10g. CITIZEN OF WHAT COU			
BY FUNERAL	8 Standard Avenue	<u> </u>				218	317				S.A.
3	11. MARITAL STATUS	12. WAS DECEDENT ET			13. WAS	DECENDENT OF HIS	PANIC	ORIGIN? (Specify Yea	or No-		— American Indian, , Whita, atc.
7	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 T	OR DATES	0		, specify Cuban, Max YES 2 NO Sp.		Puarto Rican, etc.)		Black Specif	
		1954 –	1958								White
	15, DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gi	ve kind of w	OSUAL OCCUP	ATION most of working		16b. KIND OF BUS			
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT use		0551		Eastern		recti	onal
COMPLETED	Grade 9 -		Cor	rect	ionai	Officer		Institu			
								(First, Middle, Maiden	Surname)		
BE	Bennett Sterling  19a. INFORMANT'S NAME (Type/Print)		100	MAHING	ADDRESS (C)			Landon  Number, City or Town			
5	Linda E. Sterling	(Wife)	190					risfield,			7
	20a. METHOD OF DISPOSITION	, (11220)	20b PLACEA	-	F DISPOSITION					City or Tox	
	1 K Burlel 2 Cremetion 3 Remediate Property Description 5 Other (Specify)	ovel from State	cemetery cres	natory or off	ner nlace)		5/	21/95 Cr			
,	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGEE /	9	Tage		AND ADDRESS OF			ISII	era,	MID
1	Robert & Since Bradshaw & Sons Funeral Home										
-	Robert H. Brad	dshaw, Jr.	//	2.5	306	W. Main	St	Crisfi	eld,	MD	21817
	23. PART I. Enter the diseases, or o shock, or heert failure.	complications that ca List only one cause	on each line.	ath. Do n	ot enter the	mode of dying, a	uch a	s cerdiec or reepi	story ar	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	1		2							Onset and Death
	reaulting in death)	a. /UZTAST	4mc	BRAI	0 10r	em		- <u>-</u> -			2988
		A115 411	AS A CONSEC	UENCE OF	14 1	= coco.	1				
8	Sequentielly list conditions,					(000	_				
- 1	cause. Enter UNDERLYING	if any, leading to immediate  OUE TO (OR AS A CONSEQUENCE OF):									
SAT	CAUSE (Disease or Injury  C.  DUE TO (OR AS A CONSEQUENCE OF):										+
IFICATI	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEO	resulting in death) LAST							
ERTIFICATI	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEO								
L CERTIFICATION	CAUSE (Disease or Injury that initiated eventa reaulting in death) LAST	d		aultino ir	the under	dag ceuse alven	In Dec	d 1   04- 140 AN		100	
	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	d. e contributing to dec	eth but not re	eaulting in	the underl	ying cause given	In Par	t I. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
	CAUSE (Disease or Injury that initiated eventa reaulting in death) LAST	d. e contributing to dec	eth but not re	eaulting in	the underl	ying cause given	In Par		MED?	(2)	
MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other aignificant condition	d.  e contributing to dea	eth but not re					PERFOR	MED?	(2)	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	d.  e contributing to dea	eth but not re	TH YES	S 🗆 NO	☐ UNCERTA		PERFOR	MED?	(2)	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PART II. OTHER ALGORITHMS CONTINUED TO BACCO USE CONTINUED TO MEDICAL EXAMINER?	e contributing to dec	eth but not re	TH YES	S NO	UNCERTA	AIN	PERFOR	MED?	(2)	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTE	e contributing to dea  NECROSIO  RIBUTE TO CAUS  HOSPITAL:  1   Inputlent 2   ER	SE OF DEAI 26. PLACI	TH YES	S NO H (Check only of OTHER: 4   Nursing I	UNCERTA	AIN	PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 XNO  27. MANNER OF DEATH  1 Natural 5 Pending	e contributing to dec	E OF DEAT  28. PLACE  1//Outpetlant 3	TH YES	S NO N (Check only of OTHER: 4   Nursing I OF IRY 28c.	UNCERTA	AIN	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Natural 5  Pending Investigation	RIBUTE TO CAUS  HOSPITAL: 1   Inpatient 2   ER  28a. DATE OF INJ  28a. PLACE OF IN	E OF DEAT  28. PLACE  20. PLACE  20. VOutpetiant 3  URY  SURY — At hore	OF DEATH	S NO N (Check only of OTHER: 4 Nursing I OF 28c. M 1	UNCERTA  no)  Nome 5 % Resident  INJURY AT  WORK?  YES 2 NO	AIN	PERFORI  1 YES 2  Other (Specify)  d. OESCRIBE HOW IN	MED? NO NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 XNO  27. MANNER OF DEATH  1 Natural 5 Pending	RIBUTE TO CAUS  HOSPITAL:  1   Inperient 2   ER	E OF DEAT  28. PLACE  20. PLACE  20. VOutpetiant 3  URY  SURY — At hore	OF DEATH	S NO N (Check only of OTHER: 4 Nursing I OF 28c. M 1	UNCERTA  no)  Nome 5 % Resident  INJURY AT  WORK?  YES 2 NO	AIN	PERFORI	MED? NO NO	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 XNO  27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	RIBUTE TO CAUS  HOSPITAL: 1   Inpatient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IND building, atc.	SE OF DEAI 26. PLACI 27. PLACI 28. PLACI 28. PLACI 29. P	FINAL PROPERTY OF THE PROPERTY	S NO N (Check only of OTHER: 4   Nursing I OF IRY M 1  reet, factory, c	UNCERT/ ne) tome 5 % Rasident INJURY AT WORK? YES 2 NO	AIN   28   28	PERFORI 1 YES 2  Other (Specify)  Other (Specify)  d. OEŞCRIBE HOW IN  City or Town, State)	MED?  NO  NO  JURY OC	CURED  r or Rural Ru	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO  27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be detarmined 4 Homicide Coneck only  29a. CERTIFIER (Check only  CERTIFYING PHYSII	RIBUTE TO CAUS  HOSPITAL:  1   Inperient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IN building, atc.	SE OF DEAT  26. PLACE  26. PLACE  27. VOutpetlant 3  URY — At hor (Specify)  knowledge, des	TH YES  E OF DEATH  DOA  28b. TIME INJU  ne, farm, st	S NO H (Check only of OTHER: 4   Nursing I OF 28c. III reet, factory, of	UNCERT/ ne)  tome 5 % Rasidence injury AT WORK?  YES 2 NO  ffica	28 28 28	PERFORI  1 YES 2  Other (Specify)  Id. OESCRIBE HOW IN  City or Town, State)	MED? NO NO NO NO NO NO NO NO NO NO NO NO NO	CURED  r or Rural Ru	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	RIBUTE TO CAUS  HOSPITAL: 1   Inpatient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IND building, atc.	SE OF DEAT  26. PLACE  26. PLACE  27. VOutpetlant 3  URY — At hor (Specify)  knowledge, des	TH YES  E OF DEATH  DOA  28b. TIME INJU  ne, farm, st	S NO H (Check only of OTHER: 4   Nursing I OF 28c. III reet, factory, of	UNCERTAINO  INJURY AT WORK?  YES 2 NO  Itilities and place, and con, death occurred at 1	28 28 28 Interest to the time	PERFORI  1 YES 2  Other (Specify)  d. OESCRIBE HOW IN  City or Town, State)  the cause(a) and menue, data and placa, and	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	CURED  or Rural Ruted, ted,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO  27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be detarmined 4 Homicide Coneck only  29a. CERTIFIER (Check only  CERTIFYING PHYSII	RIBUTE TO CAUS  HOSPITAL:  1   Inperient 2   ER  28a. DATE OF INJ (Month, Day, Y)  28a. PLACE OF IN building, atc.	SE OF DEAT  26. PLACE  26. PLACE  27. VOutpetlant 3  URY — At hor (Specify)  knowledge, des	TH YES  E OF DEATH  DOA  28b. TIME INJU  ne, farm, st	S NO H (Check only of OTHER: 4   Nursing I OF 28c. III' reet, factory, of	UNCERTA  INJURY AT  WORK?  VES 2 NO  Iffica  Interpretation of the control of the	28 28 10 10 10 10 10 10 10 10 10 10 10 10 10	PERFORI  1 YES 2  Other (Specify)  Id. OESCRIBE HOW IN  If. LOCATION (Street a City or Town, State)  the cause(a) and men a, data and placa, and	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	CURED  or Rural Ruted, ted,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH  1   Natural 5   Pending Investigation 2   Accident   Investigation   Accident   Acc	RIBUTE TO CAUS  HOSPITAL: 1   Inpatient 2   ER  28a. PLACE OF IN building, atc.	E OF DEAT  28. PLACI  28. PLACI  28. PLACI  (Voutpetiant 3  URY  (specify)  knowledge, des inetion and/or in	FOR DOAD	S NO H (Check only of OTHER: 4 Nursing I OF IRY M 1   reet, factory, of d at the time, of	UNCERTAINO  INJURY AT WORK?  YES 2 NO  Itilities and place, and con, death occurred at 1	28 28 10 10 10 10 10 10 10 10 10 10 10 10 10	PERFORI  1 YES 2  Other (Specify)  Id. OESCRIBE HOW IN  If. LOCATION (Street a City or Town, State)  the cause(a) and men a, data and placa, and	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	CURED  or Rural Ruted, ted,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	RIBUTE TO CAUS  HOSPITAL: 1 Inpatient 2 ER  28a. PLACE OF INJudding, atc.  CIAN: To the best of my  R: On the basis of axami	E OF DEAT  26. PLACI  26. PLACI  27. VOutpetlant 3  URY (Specify)  knowledge, des instlon and/or in	TH YES  E OF DEATH  DOA  28b. TIME INJU  ne, farm, st  westigation	S NO H (Check only of OTHER: 4 Nursing I OF IRY M 1   reet, factory, of d at the time, of i, in my opinio	UNCERTA  no)  Iome 5 % Rasident  INJURY AT  WORK?  VES 2 NO  ffica  leta and placa, and con, death occured at 1  29c. LICENSE P  29c. LICENSE P	28 28 28 28 28 28 28 28 28 28 28 28 28 2	PERFORI  1 YES 2  Other (Specify)  Id. OESCRIBE HOW IN  If. LOCATION (Street a City or Town, State)  the cause(a) and men a, data and placa, and  R	MED? NO  JURY OC  and Number  are as star  dua to the	CURED  or Rural Ruted, ted,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST  PART II. Other algnificant condition  PADIATION  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUS  HOSPITAL: 1 Inpatient 2 ER  28a. PLACE OF INJudding, atc.  CIAN: To the best of my  R: On the basis of axami	DE OF DEAT  26. PLACE	TH YESE OF DEATH  DOA  28b. TIME INJU  ne, farm, st  ath occurred restigation  127) (7/pe, 1	S NO H (Check only of OTHER: 4 Nursing I OF 28c. IRY M 1 reet, factory, of d at the time, of i, in my opinio	UNCERTA  no)  Iome 5 % Rasident  INJURY AT  WORK?  VES 2 NO  ffica  leta and placa, and con, death occured at 1  29c. LICENSE P  29c. LICENSE P	28 28 28 28 28 28 28 28 28 28 28 28 28 2	PERFORI  1 YES 2  Other (Specify)  Id. OESCRIBE HOW IN  If. LOCATION (Street a City or Town, State)  the cause(a) and men a, data and placa, and  R	MED? NO  JURY OC  and Number  are as star  dua to the	CURED  or Rural Ruted, ted,	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.

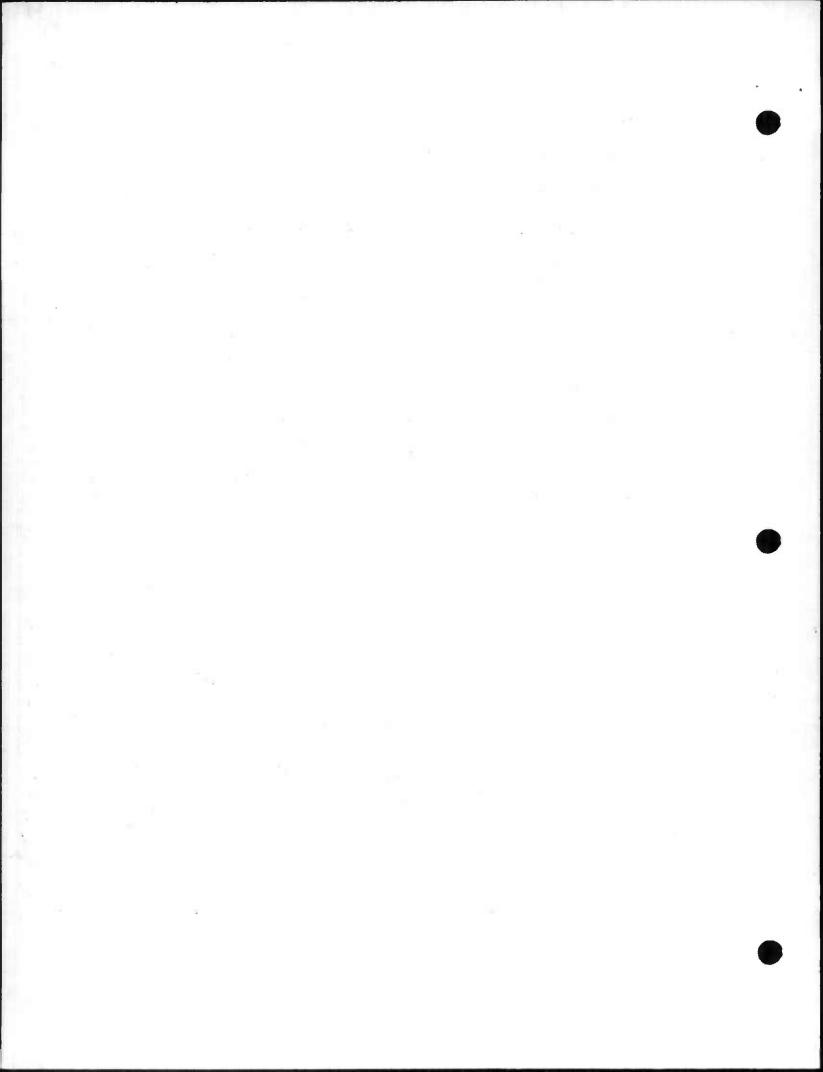
Mary 1 833 Hills of marked

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICAN. The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician,	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the medical examines must be notified at once.	
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert	) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending	filed within 72 hours after death with the State Dept. of Health and Mental Hygic	PORTANT: If Item 28 is marked, or Item 23 shows any Injury, or of	The state of the s

								9	)	8669
	FOR 1 STATE	STATE OF MAR	YLAND / DEPAI	RTMENT O	HEALTH AND	MENTA	L HYGIEN	E		
-	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE C	F DEATH		REG. NO.			
	WILMA	DARLE	I D	CDDT		MON1	OF DEATH	W	YEAR	3. TIME OF DEATH
				SPRI			31,1	995		16:30 PM
		1 M 2 TYF	GE (In yrs. last birthday)	IF UNDER 1 YE		(Mon	OF BIRTH		Countr	
	8a. FACILITY NAME (If not institution, give atree		38 YRS.				/7/195			nnsylvania
Œ					N OR LOCATION OF D	HTAB			INTY OF D	
DIRECTOR	910 OLD MANCHES	STER RD.		West	minster			CAI	RROL	L
Ä	10a. STATE 10b. COUNTY		10c. CI1	Y, TOWN OR LO	CATION					10d. INSIDE CITY
	Maryland Carr	o11	We	stmin	ster					LIMITS?
A	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CIT	IZEN OF Y	VHAT COUNTRY?
FUNERAL	910 Old Manches	ter Road			21157			Un	ite	d States
5	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 Y	R IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIO	N? (Specify Yes		14. BACE	- American Indian
BY	1 Never Married 2 Niarried 3 Widowed 4 Divorced	IF YES, DIVE WAR O			specify Cuban, Mexic YES 2 TXNO Speci		Rican, atc.)		Speci	k, White, atc.
										white
E	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION impleted)	18a. DECEDENT'S	Work done during	ATION most of working	168	b. KIND OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)								
<u>×</u>	17. FATHER'S NAME (First, Middle, Last)		superv	isor	18. MOTHER'S N.		London		q	
	Fern H. Snyder				A COLUMN TO SERVICE SE					
BE	19a. INFORMANT'S NAME (Type/Print)		10h MAII ING	ADDRESS (Co.	et and Number or Rural		Marti			
2	Robert Norman S	arinkle								ster, MD
	20a, METHOD OF DISPOSITION		20h. PLACE AND DATE	OFDISPOSITION	(Name of 12 10	E 047	200 100	PATION	City or To	
	Mariel 2 ☐ Cremetion 3 ☐ Remove 4 ☐ Donation 8 ☐ Other (Specify)	al from State	cemetery, crematory or c	(Chanas	ch Cemet	2   041	7.7.0	- 1	dily or 10	wri, state
	21. SIONATURE OF FUNERAL SERVICE LICEN		ALIGEL S	22. NAM	AND ADDRESS OF FA	ACILITY				
	EV				itts Fun					
	23. PART I. Enter the disease, or cor	00 - xweit	all	41	Washin	gtor	ı Rd.,	We	stmi	inster, MD
	anock, or heart failure. Lie	at only one cause or	aach line.	not enter the	mode of dying, so	CIT MB CMT	diac or reapi	etory an	wat,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	CONANO	- 0	05 1.1	V: 1. D					Onset and Death
	resulting in death) a.,	CONTO OR A	S A CONSEQUENCE O	Pi:	UM) OF	-Uh	31			
2										
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	F):						
5	CAUSE (Disease or Injury									
-	that initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):						
CERTIFICATION	d.									
- 1	PART II. Other algolificant conditions	contributing to deat	but not resulting	in the underl	ring cause given in	Part I.	24s, WAS AN /	NUTOPSY	24b.	WERE AUTOPSY FINDINGS
3							PERFORI			AVAILABLE PRIOR TO COMPLETION DF CAUSE
							1 YES 2	_ NO		OF DEATH?
	DID TOBACCO USE CONTRIL	BUTE TO CAUSE	OF DEATH Y	S $\square$ NO	☐ UNCERTAL	ΝП				1 YES 2 NO
PHYSICIAN: MEDICAL	26. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA							
2		OSPITAL: ☐ Inputient 2 ☐ ER/O	utpetient 3 DOA	OTHER:	lome 8 X Realdence	8 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Yea		E OF 28c.	INJURY AT WORK?	28d. DE	SCRIBE HOW IN	JURY OC	CURED	
2	1 Natural 8 Pending 2 Accident Investigation	5 31	0 -		YES 2 NO	2	M) JOCK	SI	tors	,elf
ED	3 Suicide 8 Could not be	28a. PLACE OF INJU- building, atc. (5	IRY — At home, farm, pecify)	street, factory, c	ffica	28f. LOC	ATION (Street as or Town, State)	nd Number	or Rural R	oute Number, VVO
	4 Homicide determined	Hol	45					4405	none	pesmanie
MPLE	29a. CERTIFIER 1 CERTIFYINO PHYSICIA					10 the car	use(a) and man	ner as stat	led,	
	one) 2 MEDICAL EXAMINER:									and manner as stated.
ממ	204 EIGHATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
	Marie John	Min			OCME			▶ J	UNE	01,1995
-	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	, Print)					,	_,
	ADDA PENED D. 100	KELL HM	111 P	ENN S	TREET BA	LTIN	MORE, M	IARY	LANI	21201
	JUN U 2 1995 Julia	82. REGISTRAR'S SI	GNATURE							
	3011 0 & 1333 June		PAPE .							



ALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

BAL	deat
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_	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	ехесп
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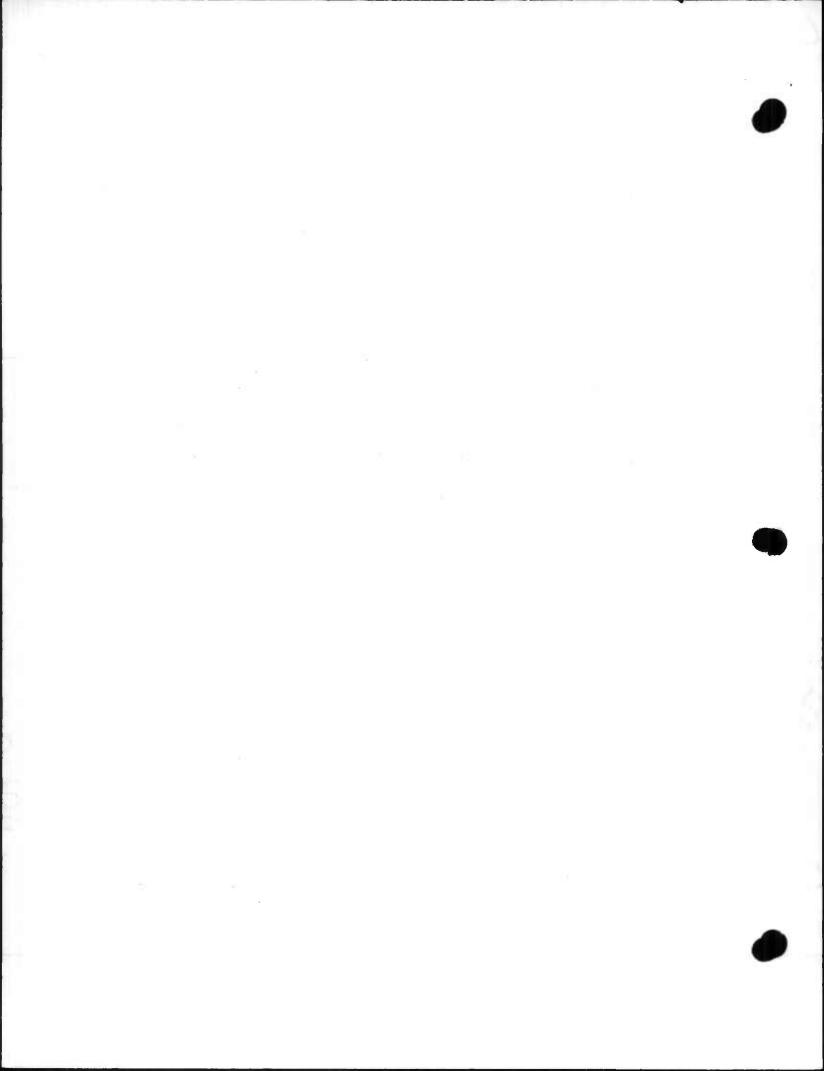
31. DATE FILED (Month, Day, Year)

JUN 0 5 1995

		1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF OEATH	AV	YEAR	3. TIME OF DEATH
			elen	Stoufi	fer						6		j .	95	/337
	1 3	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (	(In yrs. lest birt	thday) IF U	DER 1 YEAR	_	R 24 HRS.		OF BIRTH		8. BIRTH Countr	PLACE (State or Foreign
9		214-14-6524		1 🗌 M 2 🔏 F		86 '	ras.	HS DAYS	HOURS	MIN.		. 5, 1	908		nsylvania
3 should	_	9a. FACILITY NAME (If not in:	stitution, give s	treet and number)			96. (	CITY, TOWN	OR LOCAT	ION OF DE	EATH		9c. COUN	ITY OF D	EATH
~	DIRECTOR	Carroll Cou	inty Ge	eneral Ho	spit	tal		Wes	stmin	ster			Ca	rro]	.1
permit. Pages 1,	<u> </u>	10a. STATE	10b. COUNTY	1		10	c. CITY, TOV	VN OR LOC	ATION						10d. INSIDE CITY
2	8	Maryland	Ca	arroll			Unio	n Bri	idge						LIMITS?
bermi	AL.	10e. STREET AND NUMBER						_	Of. ZIP COL	DΕ			10g. CITE	ZEN OF V	VHAT COUNTRY?
TS.	FUNERAL	13 S. Farq	uhar S	St.						2179	1			U.S.	Α.
physician. burial-transit	5	11. MARITAL STATUS	ACCULATION.	12. WAS DECEDEN				13. WAS DE	ECENDENT	OF HISPAN	ANIC ORIGIN? (Specify Yea or No- 14. RACI			14. RACE	American Indian, White, etc.
20 M	BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y								offy: Specify:			fy:
by the hospital or attending the detached for use as the at once.	ED	15, DEC	EDENT'S EDU	CATION		18a DECED	ENT'S LISUA	LOCCUPAT	NON		16b. KIND OF BUSINESS/INDUSTRY			White	
or at		(Specify only Elementary/Secondary (0	highest grade	completed) College (1-4 or 5		(Give k	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					B. KIND OF BOX	3114633711410	OSIRI	
spital hed fo	귤	7	,	College (I-4 of 5	"	se	seamstress					sewing factory			·v
detach once.	BE COMPLET	17. FATNER'S NAME (First, Middle, Lest)  18. MOTHER'S NAME (First, Middle, Malden Surname)										0001			
4 be		Robert Gonder Deanne Flohr													
retained by the hospital or attending physician. 5 should be detached for use as the burial-tran- notified at once.	0	19a. INFORMANT'S NAME (7)			19b. M/	AILING ADDE	ESS (Street	and Numbe	or or Rural I	Route Nun	ober, City or Tow	n, Stata, Zip	Code)		
9 8 0	-	Robert W. Stouffer 5820 Keysville Rd. Keymar, MD 21757													
e 6 may ector, pa must t		20a METNOD OF DISPOSITE 1 ABurial 2 Crematio	n 3 🗆 Rame	oval from Stata	20b	netery, cremato	DATE OF DIS	POSITION (I	Vame of		DAT		CATION		
director,		4 Donation 5 Other  21, SIGNATURE OF FUNERAL		ENGEE /		Meadow	Y				6/5	Wes	tmins	ster	, MD
death. Pag tuneral dir i. examiner		2710	· /		1	1)	- 1	22. NAME	AND ADDRE	ESS OF FA		D. Har	tzle:	- &	Sons
the fu		Tathar	ine (	V. XVa	r/4	ler		U	nion	Brid	ge.	MD			
Te Te Te Te Te Te Te Te Te Te Te Te Te T		23. PART t. Enter the di shock, or he	seases, or c	complications the	ot caused	d the deeth.	Do not er	iter the m	ode of dy	Ing, suc	h as car	dlac or respi	ratory arre	est,	Approximate Interval Between
		IMMEDIATE CAUSE (FIN													Onset and Deal
		disease or condition resulting in desth)  a. DUTE MUDGARDIAL INFARCTION 18 HRS  DUE TO (OR AS A CONSEQUENCE OF)  Sequentielly list conditione, If any, leeding to immediate  DUE TO (OR AS A CONSEQUENCE OF):												18 HRS	
8 9 9				DUE TO	(OR AS A	A CONSEQUE	NCE OF)								
and and bur	CERTIFICATION	Sequentielly list conditi		DUE TO	POS (OR AS A	CONSEQUEN	CE OF		OKON	PRY	1/1	EART	DISE	ASE	YEARS
be chan	ÄT	cause. Enter UNDERLYING													
ertificat ing phy giene p	E	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):													
attending attending ttal Hygie y, or otl	IA	resulting in desth) LAS'	T (	d											
requires that the death certificate een signed by the attending physis of Health and Merital Hygiene pri shows any Injury, or other th		PART II. Other significe	nt condition	e contributing to	death b	out not reeu	Itles in the	underlyl	DG CBUISA	alven in	Part I	24e. WAS AN	AUTODOV	0.05	WERE AUTOPSY FINDINGS
that the dea ted by the at th and Merta any Injury,	DICAL							and city.	ing cadeo	given	rait i.	PERFOR	IMED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
signed signed Health a		5076	4,	Y ARRI	57 X						_	1 TYES 2	The		OF DEATH?
aw requires to been signed byt, of Health	W	DID TOBACCO US	SE CONTI	PIRLITE TO CA	IISE O	E DEATH	VES [	1 NO [	7 HN/	CEDTAIN					1 TYES 2 NO
has Dep	PHYSICIAN:	25. WAS CASE REFERRED TO		(IDOIL TO CA	_	26. PLACE OF				CLKIAII	<u> 1                                   </u>	<u></u>			
AN: T fficate State	Sic	EXAMINER?		HOSPITAL:	ER/Outp	patient 3 🗆 C		IER: Numina Ha	me 5 🗆 R	aaldenca	8 🗆 Othi	er (Specify)			
S cert th the	并	27. MANNER OF DEATH	- 30	28a. DATE OF (Month, E	INJURY		b. TIME OF INJURY	28c. IP	JURY AT			SCRIBE HOW II	NJURY OCC	URED	
IG PH ler thi ath wi	ВУ		Pending nvestigation	1,,,,,,,,,	,		A		YES 2	□ NO					
R: Aft er de			Could not be	28a. PLACE C building,	ofc. (Spec	- At home, t	farm, stroot,	factory, off	lea		28f. LOC City	ATION (Street a	ind Number	or Rural F	oute Number,
RECTO ALTS aft IN 28	ETE		letarmined												
AL OF	교			CIAN: To the best of											
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 s	COMPL	One) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.													
HE HE FILL BORTA	ш	296. SIGNATURE AND TITLE	OF CERTIFIER	11						ENSE NUN			29d. DATE	SIGNED	(Month, Day, Year)
5 5 3 W	0	"Jeween 1	- Q-	Les	حرسا	2	MS	7	DO	16	63		▶ 6	111	95
2	- 1	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DE	ATH (ITEM 27)	(Type, Print)	8	AN	CHO.	R	57			

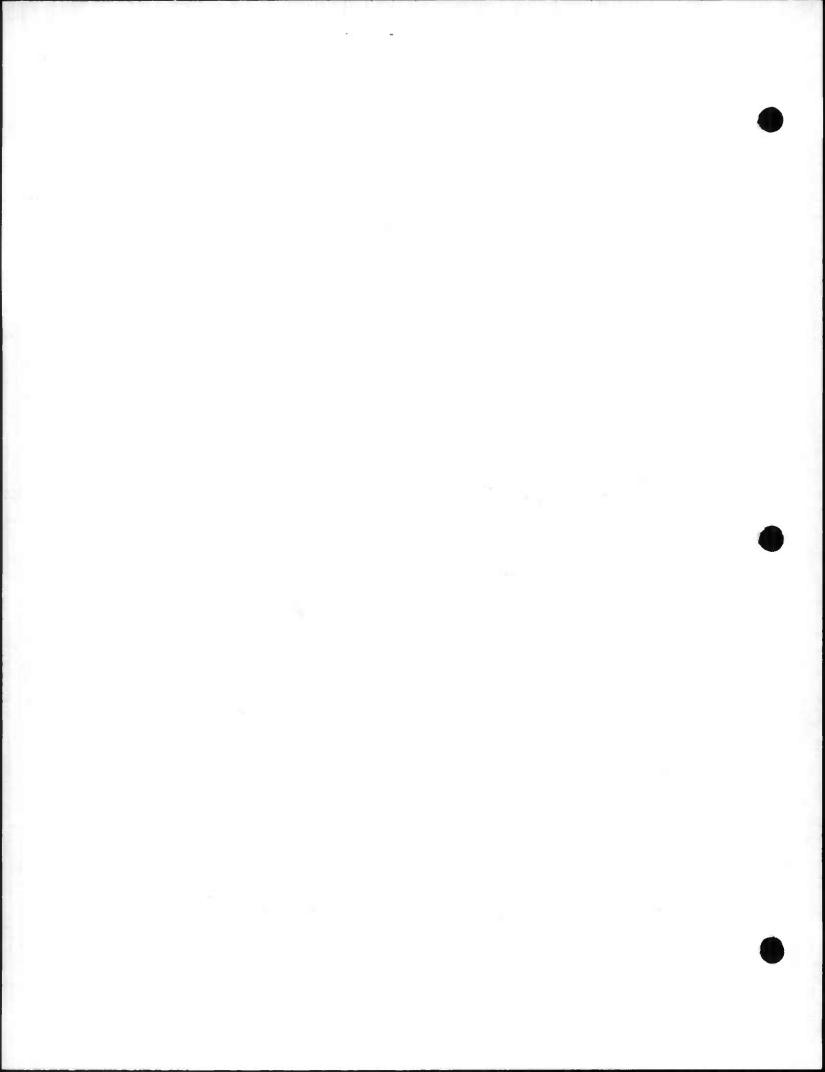
22 REGISTRANS SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



É	age 6	direct
DALLIM	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct
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	within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
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	1 - FOR STATE (	F MARYLAND / DI CER	EPARTMENT OF H		NTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest) ANNA	JOSEPHI		ANN 2.	DATE OF DEATH DAY 199	5 YEAR	3. TIME OF DEATH 9:25 P M				
	4. SOCIAL SECURITY NUMBER 5. SEX 577-18-7971 1 M 2 2  9e. FACILITY NAME (If not institution, give street and number	/8	YRS. MONTHS DAYS	HOURS MIN.		17 Wa	shington				
CTOR	PHYSICIANS MEMORIAL HO		LA PLAT			ARLES	EATN				
DIRE	Maryland Charles  10e. STREET AND NUMBER	-10	Indian	Head			10d. INSIDE CITY LIMITS? 1 YES 2 XHO				
INERAL	6 Blair Rd., Apt. 2	O 1		20640		U.S.A					
BY FU	1 Never Married 2 Married FORCES?	1 YES 2 NO VE WAR OR DATES	If yes, spe		IDENT OF HISPANIC ORIGIN? (Specify Yes or No— ify Cuben, Mexican, Puerto Ricen, etc.)  IN No Specify:  White						
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	(Give k He. Do	DENT'S USUAL OCCUPATION find of work done during most NOT use retired.)	ON st of working	16b. KIND OF BUSINESS/I	NOUSTRY	William				
COMPL	12 Retail Clerk Store  17. FATHER'S NAME (First, Middle, Last)  William Quade  Retail Clerk  18. MOTHER'S NAME (First, Middle, Maiden Surname)  Marie O'Brien										
TO BE	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
17. FATHER'S NAME (First, Middle, Last)  William Quade  19a. INFORMANT'S NAME (Type/Print)  Judy McOwen  1045 100 1st., Niagara Falls, NY. 1  20a. METHOD OF DISPOSITION 1 Removal from State of Disposition 1 Charles of Funeral Service Licensee  20b. PLACE AND DATE OF DISPOSITION (Name of June 5DATE 9) 505. Location — City or Town, State cometery, cremalory or other place)  St. Charles Cemetery State of Facility  Williams Funeral Home, P.A.  MO0668 Rt. 225 & Clymont Pd. India											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Williams Funeral Home, P.A.  M00668 Rt. 225 & Glymont Rd., Indian Head										
Williams Funeral Home, P. 2  MO0668 Rt. 225 & Glymont Rd., Inc.  22. PART Lenter the diseases, or complications that charsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (on AS A CONSEQUENCE OF):  DUE TO (on AS A CONSEQUENCE OF):											
MEDICAL CI	PART II. Other significant conditions contributing	to deeth but not resu	ilting in the underlying	ceuse given in Pari	24s. WAS AN AUTOPS PERFORMED  1 YES 2 NO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO				
SICIAN: I	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERBED TO MEDICAL EXAMINER?	26. PLACE OF	F DEATH (Check only one)	UNCERTAIN E	<u> </u>						
РНУ	27. MANNER OF DEATH  1 V Naturel 5 Pending (Mor	2 ER/Outpetient 3 ( E OF INJURY 28 th, Day, Year)	DOA 4 Nursing Home  1b. TIME OF 1NJURY 28c. INJURY		Other (Specify)  d. DESCRIBE HOW INJURY O	CCURED					
E E	3 Suicide 8 Could not be 28s. PLA	CE OF INJURY — At home, ling, stc. (Specify)	ferm, street, factory, office	281	LOCATION (Street and Numb City or Town, State)	per or Rural Ro	oute Number,				
121	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the be composed to the composed to						and manner as stated.				
TO BE COM	296. SIGNATURE AND TITLE OF CERTIFIER  WWW. Jewitt	12/9	(Month, Day, Year)								
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED Michael Leatherwood, M.	D	Waldo	orf Medica orf, Maryla	1 Park,PO Bo and 20604	x 249					
	31. DATE FILEO (MONIN, Day, 1941) 1995 32. 009	THAR'S SIGNATURE	all								



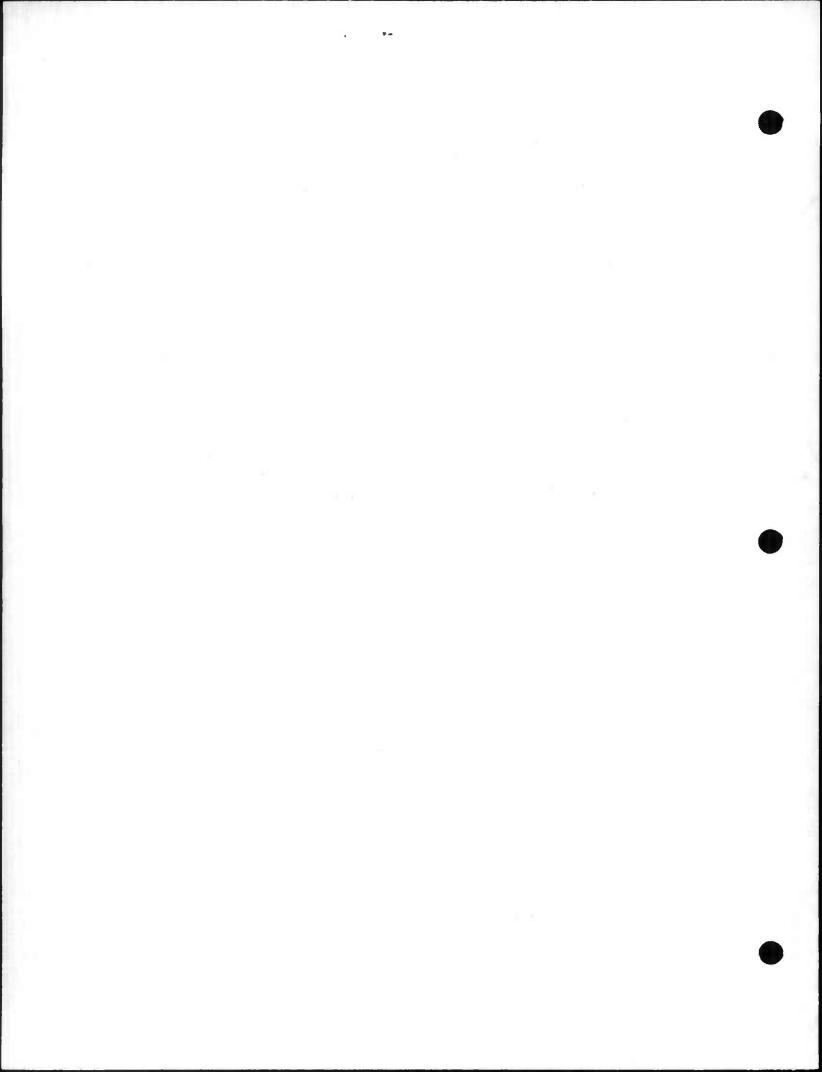
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

					Lat I I I I	TOATE	. 01	DEATH		HEG. NO.			
	1. DECEDENT'S NAME (First, I BARBARA	Middle, Last) J0	AN ST	<b>TEPHENS</b>					2. DAT	TH 30, I	995	YEAR	3. TIME OF OEATH 1:35 PM M
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE	E OF BIRTH		S. BIRTH	IPLACE (State or Foreign
	098-34-7441		1 🗆 M 2 💢 F	51	YRS.	MONTHS	DAYS	HOURS MIN.	MAR	RCH 25,	44	Countr	NECTICUT
~	9e. FACILITY NAME (If not inst					9b. CITY,		OR LOCATION OF 1	HTASC		9c. COU	NTY OF O	EATH
DIRECTOR	WALDORF HEAL		E CENTER				W	ALDORF				CHAI	RLES
S		10b. COUNT	Y		10c, CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY
	MARYLAND	СН	ARLES			WALD	ORF						LIMITS?
FUNERAL	100. STREET AND NUMBER 1237 ADAMS R	OAD					101	ZIP CODE 206	502		100		STATES
S	11. MARITAL STATUS		12. WAS DECEDEN	T_EVER IN U.S. A	RMED	13. V	WAS DEC	ENDENT OF HISPA		IN7 (Specify Yes			- American Indian.
BY F	1 Never Married 2 No	farried ed	FORCES? 1	X YES 2 AR OR DATES	]NO		yes, sp	ecify Cuban, Maxk 2 NO Spec	en, Puerto	Rican, etc.)		Black	TITE
8		DENT'S EDU	CATION	16a, D	ECEDENT'S	USUAL OC	CUPATIO	ON	16	b. KINO OF BUS	INESS/INC		17.15
I III	(Specify only : Elementary/Secondary (0-1		College (1-4 or 5 +	) #	le. Do NOT u	se retired.)		st of working					
COMPLETED			7	PUI	BLIC	HEALT	HN	URSE		H	OSPIT	ΓAL	
Ö	17. FATHER'S NAME (First, Mid	idle, Last)						18. MOTHER'S N					
BE	JOSEPH ADAMS							ELIZAE	BETH	BUNCZA	K		
0	JERRY S. STE							and Number or Rura					
1							_	AD, WALE	ORF,			2060	
	1 A Sturiel 2 Department on 4 Department on 1	3 D Rem	ovel from State		AND DATE			CEM. JU	JNE 2	1995	CHE	City or To	WII, Stefa KHAM. MD
	MGB COLLEGE	SERVICE US	MISEE CO.	/		22 L	AME AN	UNTT FUN	ACILITY IC D A I	HOME	TNC		
	MARK G.	BROH	AWN	M0005	53	Ρ.	0.B	OX 156 W	IALDO	RF. MAI	RYL AN	ND 20	0604
	23. PART I. Enter the dis	easea, or o	complications that	caused the d	leath. Do	not enter	the mo	de of dylng, su	ch as car	rdiac or reapi	ratory an	reat,	Approximate
	IMMEDIATE CAUSE (Fine	shock, or heart fallure. List only one ceuse on eech line.  IMMEDIAC AUSE (Fine)  Onset and Death  Onset and Death											
1	disease or condition resulting in death)	<b>&gt;</b>		Rast	r (	Gru	5						-fears
1.3			DUE TO	(OR AS A CONSI	EQUENCE O	F):							1-1
NO	Sequentially list condition	ns,	b	· · · · · · · · · · · · · · · · · · ·									
CERTIFICATION	if any, leeding to immedicause. Enter UNDERLYIN		DUE 10	(OR AS A CONSE	EQUENCE O	F):							1
FIC	CAUSE (Diseese or Injury that initiated events		c. OUE TO	OR AS A CONSE	EQUENCE O	P):							
E	resulting in death) LAST					,							i l
S			a										1
AL	PART II. Other aignificant	condition	s contributing to	death but not	resulting	in the und	derlying	g cause given in	Part i.	24s, WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
EDICAL										1 - YES 2	X NO		COMPLETION OF CAUSE OF DEATH?
Σ													1   YES 2   NO
SICIAN:	DID TOBACCO US		RIBUTE TO CA					UNCERTA	N 🗆				
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLA	CE OF DEA	OTHER							
ΥS	1 VES 2 NO		1 Inpatient 2		_	Nurs	ing Hom	e 5 🗆 Residence					
РНҮ	27. MANNER OF DEATH  Natural 5 P	ending	28e, DATE OF (Month, De	INJURY Iy, Year)	28b. TIM	E OF		RK?	28d. DE	SCRIBE HOW I	NURY OC	CURED	
ВУ	2 Accident In	veatigation	260 PLACE OF	F INJURY At h				rES 2 NO					
TED		ould not be starmined	building,	etc. (Specify)	ome, rerm,	street, racto	чу, отне	•	City	CATION (Street a or Town, State)	nd Number	or Rural R	loute Number,
LET	290. CERTIFIER	YING PHYSI	CIAN: To the best of	my knowledne d	leath occur	ad at the tie	no deta	and plans and du	di de la				
COMPL													) and manner se stated.
		PCERTIFIE						290-LICENSE NU					(Month, Day, Year)
BE	11/	1) +	tal				ł	1727:	349				1, 1995
유	30. NAME AND ADDRESS OF								, , ,				
	HOWARD MARK H		M.D., 70	O OLD L	INE C	ENTE	R, #	100, WA	LDORI	F, MARY	LAND	206	02
	31. DATE FILED (Month, Day, Ye JUN 0	6 199!	5 Julia	Distribution .	Revolati								



BALTIMORE, MARYLAND 21215-0020

thin c. hours after death. Page 6 may be retained by the hospital or attending physician.

Where it is not the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 is

phone

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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DALI IMORE,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with mest hours after death. Page 6 may b	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pag be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be
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	TA	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fibe within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	=
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31. DATE FILED (Month, Day, Year)

JUN 05

CHESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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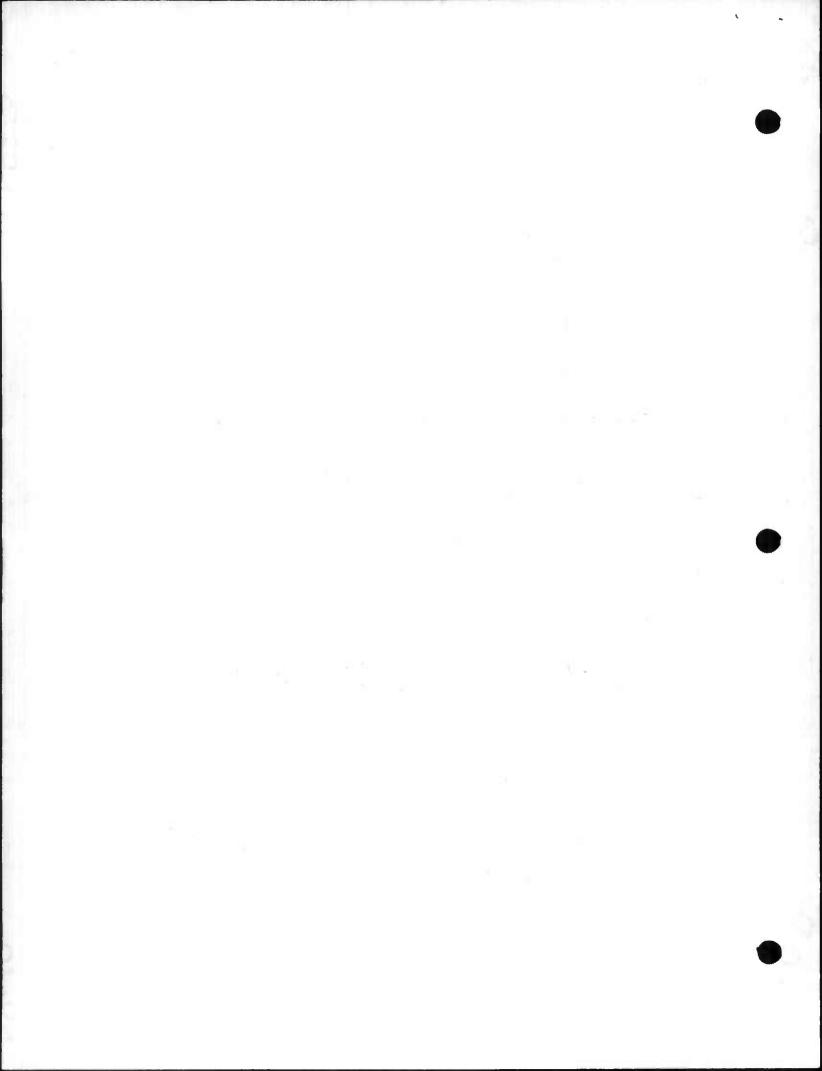
32. REGISTRAR'S SIGNATURE

ili Davelson Rarlett

70

95 18673 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Lest) 2. DATE OF DEATH S- 25 Myrtle Viola Slick 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State (Morith, Day, ) 4/1/22 1 M 2 X F HOURS 282-12-4727 VRS 73 Ohio 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Knoxville 1 - YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2071 Hoffmaster Road 21758 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 N NO BY Specify: 3 [X] Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 10 Housewife Homemaker 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surne Ħ Oscar Otis Hosler BE Goldie Viola Fox notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Darrin R. Slick 2071 Hoffmaster Road - Knoxville, MD 21758 9 20e. METHOD OF DISPOSITION
1 X Burlai 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Samples Manor Cemetery 4 Donation 5 Other (Specify) 6/6 Sharpsburg, MD the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eackles-Spencer Funeral Home Harpers Ferry, WV 25425 23. PART i. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heert fallure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition\_ 30 WL reculting in death) shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) sinato 50 CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING 102 X20 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART If. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMALAINLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY 1 TYES 2 12 NO kenoro 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN [] Item 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? OTHER: nt 2 - ER/Outpatient 3 - DOA 4 - Hursing Home 5 - Residence 6 - Other (Specify) marked, or 37. MANNETT OF DEATH (Month, Day, 1847) 28b. TIME OF 20c. INJUNY AT WORKT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Sciently) 3 [ ] Suicide Item 28 Is 28f. LOCATION (Street and Number or Flurel Route Number City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER \* CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pieca, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296, SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE/SIGNED (Mpnth, Day, Year)

taperstown

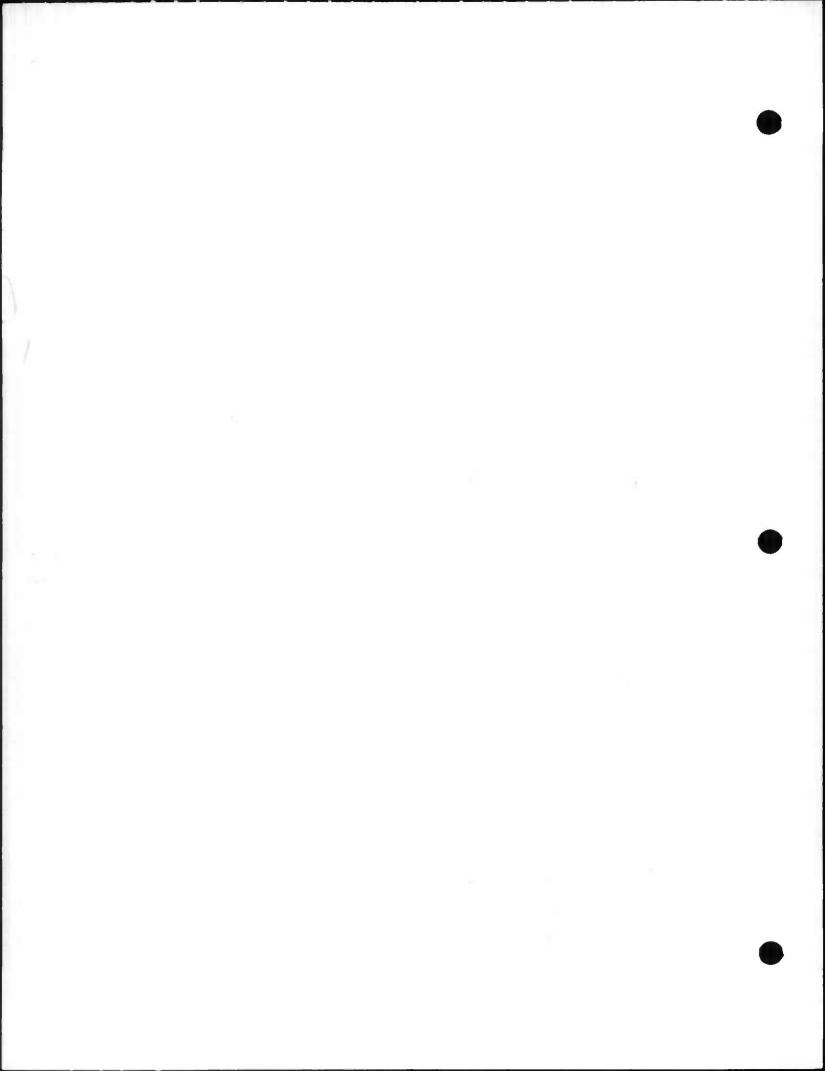


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the tuneral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

# Amended #17, 6/5/95, LH., Fred. Co. 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	HIIF	ICATE	OF	DEATH		RE	G. NO.			
	t. DECEDENT'S NAME (First, Middle, Last) Rut	h Eleano	r	S	AWYEI	R		2. N	pate of de Month lay 31	L, T	995	YEAR	3. TIME OF DEATH 8:50 AM M
	4. SOCIAL SECURITY NUMBER 011-36-7875	5. SEX 8.	AGE (In yrs. las	t birthday) YRS.	IF UNDER MONTHS	1 YEAR DAYS	IF UNDER 24 HR		Month, Days	****19	08		PLACE (State or Foreign Schusetts
	Se. FACILITY NAME (If not institution, give s				,		R LOCATION O	F DEATN				JNTY OF D	
DIRECTOR	Northampton Man		Home		F	rede	rick				Fr	reder	rick
J. BE	Mass. Midd	lesex			y, town o		TON						tod. INSIDE CITY LIMITS? t YES 2 NO
	10e. STREET AND NUMBER						. ZIP CODE				t0g, CIT	IZEN OF V	t-1 YES 2 NO WHAT COUNTRY?
FUNERAL	15 Stone Road						02178					U.S.	Α.
	tt, MARITAL STATUS t X Nover Married 2 Married	12. WAS DECEDENT ET FORCES? 1   IF YES, GIVE WAR	YES 2 N	MED	11	yes, sp	ENDENT OF NIS	exican, Pu	RIGIN? (Spe Jarto Rican, d	etc.)	or No-	Black	— American Indian, k, White, etc.
B√	3 Wildowed 4 Divorced		ON DATES		<u> </u>		2 M NO Sp	pec/fy:				Speci	White
ETE	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	completed)	t6a. DE	CEDENT'S we kind of v Do NOT us	USUAL OC vork done d retired.)	CUPATIO	ON at of working		18b. KIND	OF BUSI	NESS/IN	OUSTRY	
COMPLETED	Elementary/Secondary (U-12)	College (1-4 or 5+)	S	choo	1 Tea	ache	r		Educ	cati	on		
	17. FATNER'S NAME (First, Middle, Last) Frederick Ernest	Smith SWA	YER So	21.11.10			18. MOTHER'S		First, Middle,			CR CR	
O BE	19a. INFORMANT'S NAME (Type/Print)		198	. MAILÍNO	ADDRESS	(Street a	nd Number or Ru	ural Route	Number, City	or Town.	State. Zi	p Code)	
5	Frederick R. Wil		1	0109	Johr	ns D	rive,	Dama	scus,	Ma	ryla	and 2	0872
	204_METHOD OF DISPOSITION t ABurlel 2 Cremation Management 4 Donation 6 Other (Specify)	oval from State	20b. PLACE A				June 9	9,199	DATE 2			idge,	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. P	NAME AN	and B	F FACILIT	γ	Δ	Fune	ara1	Ноте
_	23. PART i. Enter the diseases, or o	, JUNGY	M002		110	6 Ea	st Chu	irch	St	Fre	deri	ick	Md. 21701
	ahock, or heart failure.	List only one cause	on aach iine.	atti. Do n	ot entar	tne mo	da of dying, s	such aa	cardiac oi	r reapin	itory an	reat,	Approximata interval Between Onset and Death
		DUE TO (OR	NTIA										BYK
_						1/6.		1.00					2 DAYS
Š	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEC	UENCE OF	7:	VEL	KNON	114					Z DA73
2	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEO	LIENCE OF	J.								
CERTIFICATION	resulting in death) LAST	1											
- 1	PART II. Other eignificant condition	a contributing to das	ith but not re	sulting I	n tha unc	dariying	cause givan	in Part	i. 24a. V	MAS AN A		246.	WERE AUTOPSY FINDINGS
DICAL	DEP RESSION	N, 05.	FEDAR	THE	2177	J				YES 2	-		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	DID TORACCO LISE CONTE	NOUTE TO CAUC	F OF DEAT	F11 \/F		10.0			_				1 TYES 2 THO
PHYSICIAN: M	DID TOBACCO USE CONTR	IBUIE IO CAUS			H (Check o		UNCERIA	AIN L					
YSIC	EXAMINER?	HOSPITAL: 1   Inpatient 2   ER	/Outpatient 3	□ DOA	OTHER 4 Rural	: ing Nome	5 - Residen	ice 6 🗆	Other (Speci	lty)			
ВУ РН	27. MANNER OF DEATN  t Natural 5 Pending  2 Accident Investigation	26a. DATE OF INJ (Month, Day, Y		28b, TIME INJ	OF URY M		URY AT RK? ES 2 NO	28d	. DESCRIBE	HOW IN	JURY OC	CURED	
	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined	26e. PLACE OF IN building, atc.	JURY — At hor (Specify)	ne, ferm, s	treet, tecto	ry, office		261.	LOCATION (	(Street are	d Number	r or Rural R	loute Number,
	29a. CERTIFIER (Check only	CAN: To the heat of my	knowledge des	th accume	el es she she			201.000					
COMPLET	(Check only one) 2 MEDICAL EXAMINE												and menner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	Some	Ium				29c. LICENSE I						(Month, Day, Year) 1, 1995
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE O	F OEATH (ITEM										
	Dr. Andrew O. Don					se A	ve., F	rede	rick,	Ma	ryla	nd 2	1701
	JUN 0 2 1995	32. REDISTRAR'S	SIGNATURE	relate									
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		CHARLE		6				-	SPR	NE	7	Mai	1 20	1
		4. SOCIAL SECURITY NUMBER 577-16-530		5. SEX	6. AGE (I			IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE O	BIRTH Day_Year	
9	1			1 🖾 M 2 🗆 F		76	YRS.					June	25,19	₹18
3 should	œ	99. FACILITY NAME (If not in Suburban H						9b. CIT	Y, TOWN O	esda		ATH		9c. COI
N.	5	RESIDENCE OF DEC	-117			_			beth	esua				Mo
See	DIRECTOR	10s. STATE	10b. COUNT						OR LOCAT					
		Maryland		iontgomer	У		K	ensi	ingto	n				
L bed	3AL	104. STREET AND NUMBER							101.	ZIP COD				10g. CI
020 physician. burlal-transit permit. Pages 1,	FUNERAL	10112 Thor	nwood								895			
)20 hysic ourial-		11. MARITAL STATUS 1 Never Married 2 🔀	Married	12. WAS DECEDED FORCES?	YES	2 N		13.	If yes, spe	cify Cube	n, Mexicar	IC ORIGIN?	(Specify Ye	s or No-
215-0020 attending physician. se as the burial-trar	B	3 Widowed 4 Dive	erced	WW II		TES			1 TYES	2 X NO	Specify	,		
1215 r attend use as	ETED		EDENT'S EDU						CCUPATIO			16b. I	(IND OF BU	SINESS/IN
ND 21 hospital or ached for u		Elementary/Secondary (		College (1-4 or 5	+)	Mo.	Do NOT us	<ul><li>retired.)</li></ul>					70	
AND the hospi	COMPL	AT PATHERIE MANGE (C		3 years	+	Dan	K V.	P. 0	Trus					ankin
YLA by the be dett		17. FATHER'S NAME (First, M Charles Be		Spring.	Sr.							WE (First, Mid Cona		Sumame)
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.	BE	19a. INFORMANT'S NAME (		-10,		19b.	MAILING	ADORES	S (Street of			loute Numbe		un State 7
M/ e reta e 5 st	٤	Mrs. Katha	rine I	Lease Spr	ing							Kens		
ALTIMORE, death. Page 6 may be the sector, page		20e. METHOD OF DISPOSIT 1    Burlel 2   Cremetic		ount from Ctoto	20b.	PLACEA	NDDATEC	F DISPO	SITION (Na	me of		DATE	20c. LC	CATION -
MORI ge 6 maj lector, p		4 Donation 5 Other		IOVEL HOIR STATE	Mt	tery, On	erved		mete			5/31		deri
ALTIN death. Pag		21. SIGNATURE OF FONERA	L BEHVICK H	CENSEE)	m/			22. RC	BERT	D ADDRES	DATT.	EY &	SON	FIINEE
40 41 7 7		Dokut	CX	airy	14	7						ST.		
Cours after of in by the or remove	П	23. RART I. Enter the d	seases, or	Listonly one car	besue	the des	th. Do n	ot ente	the mod	de of dyl	ng, such	ae cerdia	c or reap	iratory ar
The Pool	1 1	IMMEDIATE CAUSE (Fir		Casponiy one car	Oli ea	on line.	,	,	,					
A marky		disease or condition resulting in death)	<b>→</b>		cheu		H	car	+	DIS	eas	0		
68760 secuted with and complete burial, orem		Anna Service Control Co.		DUE TO	(OR AS A	CONSEC	JENCE OF	):						
P.O. BOX 68 h certificate be enough ending physician and c Hygiene prior to burin or other traumatic	NO.	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):												
BOX calls be as hysician a phor to ar fraum	CERTIFICATION	cause. Enter UNDERLYING												
O nather	Ē	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF):												
= = =	H	resulting in death) LAST												
RECORDS, requires that the dear signed by the att of Health and Menta shows any Inlury.		PART II. Other algolitica	nt condition	e contributing to	deeth bu	t not re	eulting i	n the u	nderlying	couse g	lven in f	Part I. 2	4a. WAS AR	
ECORE  pulres that the signed by the Health and lives any lives and lives any lives and lives any lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives any lives and lives any lives and lives any lives and lives any lives any lives any lives any lives any lives any lives any lives any lives any lives any lives any lives and lives any lives any lives any lives any lives any lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives any lives and lives and lives any lives and lives any lives and lives any lives and lives an	MEDICAL	6											PERFO	
RECorrections and reality of Health	MEC											_		. [5]
2 D W m	ä	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF	DEAT	H YE	s 🔲	NO 🗆	UNC	ERTAIN			
F 8 8 8	PHYSICIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	2	6. PLACE	OF DEAT	H (Check						
ICIAN:	ΥSI	1 DYES 2 NO		1 Inpetient 2		tient 3		4 🗆 Nui	sing Home		sidencs (	B ☐ Other (	Specify)	
O St state of		27. MANNER OF DEATH  1 Netural 5	Pending	26s. DATE OF (Month, D		i	28b. TIME INJU	OF JRY	28c, INJU WOF	NY?		26d. DESC	RIBE HOW	NJURY OC
ONG PING After death	ВУ	2 Accident	Investigation	26s. PLACE C	F INJURY -	– At hom	e, farm «	treat for	1 Y	ES 2	NO	261. LOCAT	ION /Stead	and Mumba
DIVISION OR ATTENDING I DIRECTOR: After hours after death			Could not be determined	building,	etc. (Specif	y)	.,,		tory, ornee			City or	Town, State,	ina Numbe
OR OR	LET	290. CERTIFIER	IFYING PHYSI	CIAN: To the best of	my knowle	don don	h occurre	d at the t	time data	and place	and due t	to the source	(a) and	
<b>M M M M M M M M M M</b>	COMPL			R: On the besie of a										
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	ШСС	296. SIGNATURE AND TITLE				_				29c. LICE	NSE NUM	ВЕЯ		29d. DA1
TO THE HOSPIT TO THE FUNER be filed within		Xan,	Dro	when	M	0				M	0 38	3888	)	<b>&gt;</b> <
	유	30. NAME AND ADDRESS OF	PERSON NA	O COMPLETED CAU	SE OF DEA	TH (ITEM	27) (Type,	Print)	1 .	. / ; !	1.		11	
		Harry	13	1949m	6	71	OR	xki	ledg	PP	rive	013e	160	sola
		31 DATE EN ED (Month Day	Mari	1 32 OCHIOTOR	DIE GIOCIA	TLIME	and the same of		7			9		

32. REGISTRARIS SIGNATURE

filla d'audion Radall

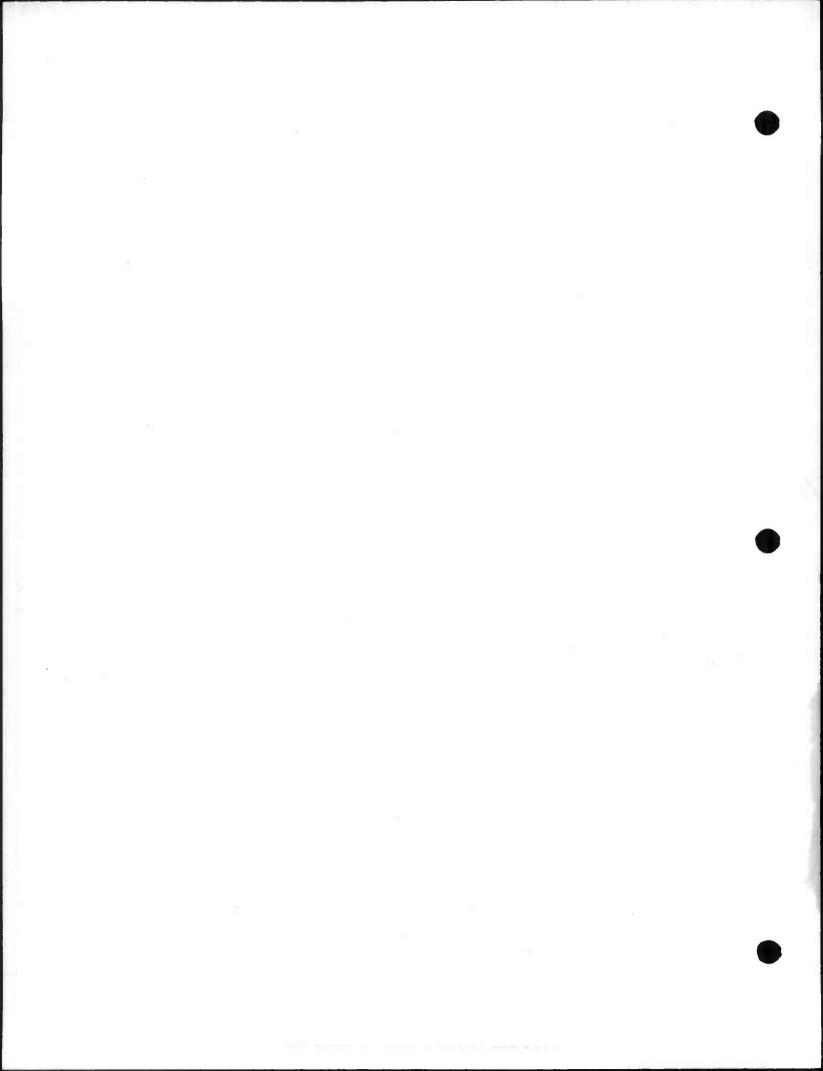
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'B NAME (First, Middle, Last)

95 18675 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF OEATH 3. TIME OF DEATH OF BIRTH 1225 1995 B. BIRTHPLACE (State or Foreign 25,1918 Virginia 9c. COUNTY OF DEATH Montgomery 10d, INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. N? (Specify Yes or No-Ricen, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White b. KIND OF BUSINESS/INDUSTRY Banking Middle, Maiden Sumame) nard ober, City or Town, State, Zip Code) sington, Md. 20895 20c. LOCATION — City or Town, State Frederick, Md. 21701 SON FUNERAL HOMES, P.A. FREDERICK, MD. 2170-1 diac or respiratory arrest, Approximate **Onset and Death** 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 TO NO OF DEATH? 1 YES 2 DING SCRIBE HOW INJURY OCCURED CATION (Street and Number or Rural Route Number, or Town, State) use(s) and menner se stated. and place, and due to the ceuse(s) and manner as stated. 29d. DATE SIGNED (Morgh, Day, Year)

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HI	EALTH AND DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest)	15ta 51.	mmor	15		2. DATE OF DEATH DATE OF DEATH DATE	"4 19	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-32-2978	1 🗆 M 2 🛣 F		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec 6,	1	BIRTHPLACE (State or Foreign Country)  Maryland
OR	90. FACILITY NAME (If not institution, give si Harford Memoria				de Gr			of DEATH ford
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION	DN			10d. INSIDE CITY
	Maryland Hari	ord	Aber		ZIP CODE		100 CITIZE	1 ŽYES 2 □ NO N OF WHAT COUNTRY?
FUNERAL	953 Edmund St				21001		US	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2-1 NO	If yea, spec	NDENT OF NISPAI cify Cuben, Mexice 2 ANO Specif	NIC ORIGIN? (Specify Yea on, Puerto Rican, atc.) y:	or No- 14	I. RACE — American Indien, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during most	of working	16b. KIND OF BU	Contract Contract	STRY
OME	12 years 17. FATNER'S NAME (First, Middle, Lest)				18. MOTNER'S NA	Civil ME (First, Middle, Maiden		7ice
BE 0	Thomas Lingham	1			Lillia			
٥	Joseph Albert	Simmons		9		Aberdeen		vland 21001
	20s METNOD OF DISPOSITION 1 A Burlet 2 Cremetton 3 Remo	205	PLACE AND DATE OF elery, cremeter y or other Langes	DIOGOGITICAL III		OATE 20c. LO	CATION - CH	y or Town, State
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	thenfe	t James	22. NAME AND	ADDRESS OF FA	CILITY		de Grace,MD Lewis Street
H	23. PART I. Enter the diseases, de-C	omplications that caused	the death. Do not	Havre	e de Gi	cace. Mar	vland	21078
	shock, or heart failure. ( IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on ea	LMO Mas				200	Interval Between Onset and Death
	tooking in doziny		CONSEQUENCE OF):					
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
MEDICAL C	Adeno Carainon	contributing to death be	it not resulting in	the underlying		Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
N: N	DID TOBACCO USE CONTR				UNCERTAIL	v 🗆		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 250 NO	HOSPITAL: 1   Inpatient 2   ER/Output		THER:	8 🗆 Basidanas	6 Other (Specify)		
	27. MANNER OF DEATN  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y 28c. INJU	RY AT	28d. DESCRIBE NOW II	NJURY OCCUP	NED
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined	26e. PLACE OF INJURY building, atc. (Speci	At home, ferm, stre		S 2 NO	281. LOCATION (Street a City or Town, Stete)	and Number or	Rural Route Number,
COMPLETED		CIAN: To the best of my knowled.  So On the basis of examination						ouse(e) and manner so stated.
8	296. SIGNATURE AND TITLE OF CERTIFIER				1) 32-6		29d. DATE S	IGNEO (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO KAMMADIN MU	ly and MD		Lution	n st · t2 n	Parre De	Go	zu M) 21 U78
	31. OATE FILEO (MORITI, Day, Year)  JUN 0 6 1995	M. REGISTRAR'S SIGNA	Rarlall					

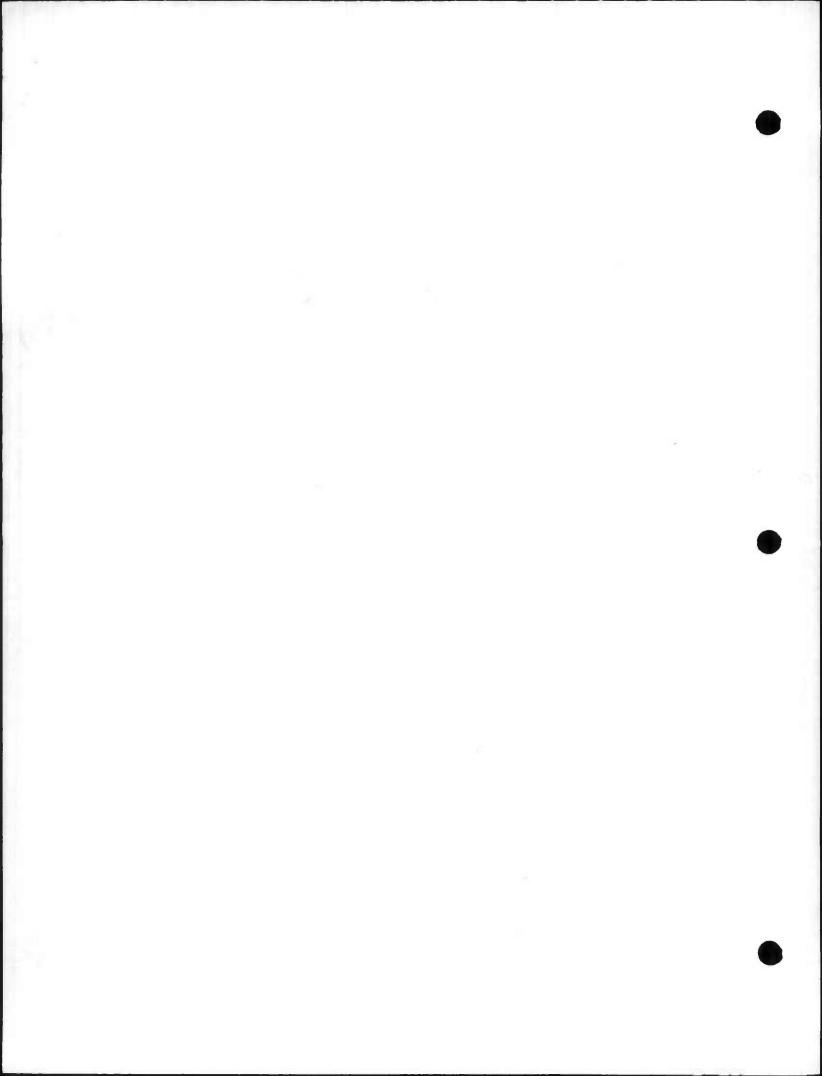


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

5

					9	5 186//
	1 - FOR STATE OF MARYLAND / D REGISTRAR CEF	EPARTMENT (		NENTAL HYGIEI		
	1. DECEDENT'S NAME (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH
	Margaret Smith Marie					5 0754 M
	of Aut In 113. Aut of		AYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTHPLACE (State or Foreign Country)
l j	219-05-3635 1 M 2 XF 73		WN OR LOCATION OF DEA	01-03-22	Maryland Y OF DEATH	
DIRECTOR	Peninsula Regional Medical Center	Salis			Wicom	
ĒC		10c. CITY, TOWN OR	OCATION			10d. INSIDE CITY
	Maryland Wicomico	Salis	bury 101, ZIP CODE			LIMITS?  1 YES 2 NO  N OF WHAT COUNTRY?
FUNERAL	825 West Road		21801		U.S.	
NO	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARME	D 13. WA	DECENDENT OF HISPANI	C ORIGIN? (Specify Ye		. RACE — American Indian.
BY F	1 Never Married 2 Married  3 N Widowed 4 Divorced  FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		vs, specify Cuben, Maxican.   YES 2 NO Specify:			Black, White, etc. Specify:
ED B						Black
ETE	(Specify only highest grade completed) (Give	DENT'S USUAL OCCU kind of work done durn o NOT use retired.)		16b. KIND OF BI	JSINESS/INDUS	TRY
PLE	Elementary/Secondary (0-12) College (1-4 or 5 +)	Domesti	C	1	None	
COMPL	17. FATHER'S NAME (First, Middle, Last)	DOMCDOI		IE (First, Middle, Maide		
BE C	John Gale		Georgi	anna Go	slee	
0 8	19a, INFORMANT'S NAME (Type/Print) 19b. 8	MAILING ADDRESS (S	treet and Number or Rural Ro			ode)
	Bethenia Golden 20		ie St.Spr			
	1 Burial 2 Cremation 3 Removal from State cemetery, crema	D DATE OF DISPOSITION or other place)	ON (Name of	61.		y or Town, Stata
- 8	4 Donation 6 Other (Specify) Head  21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Of Cree	ME AND ADDRESS OF FAC	7 00	antico	o,Md.
	N TEN IN THE STATE OF THE STATE		ewart Fun		ne	
	Blady B. Stewart		West Rd.			
	<ol> <li>PART I. Enter the di∮esses, or complications that caused the desti ahock, or heert failure. List only one cause on each line.</li> </ol>	h. Do not enter th	mode of dying, such	ss cerdiec or real	piratory arres	interval Between
	iMMEDIATE CAUSE (Final disease or condition					Onset and Death
	resulting in death) s. Arteriosclerotic		ascular Dis	ease		years
z						
TIO	Sequentielly list conditions, if any, leading to immediate	ENCE OF):				
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury the billithese services or injury	ENCE OF				
T.	that initiated events resulting in deeth) LAST	ENCE OF):				
CEI	d					
AL.	PART II. Other aignificant conditions contributing to deeth but not res	uiting in the unde	rlying cause given in F		N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL				1 YES	з Жио	COMPLETION OF CAUSE OF DEATH?
Σ	<del></del>			-		1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL					
Sic	EXAMINER?  14 YES 2 NO  NO SPITAL:  1   Inpatient 2   ER/Outpetlant 3	OTHER:	26. PLACE OF DEATH (Chec			
H	27. MANNER OF DEATH 28a. DATE OF INJURY 2	28b. TIME OF 28	Home 5 Residence 6	26d. DESCRIBE HOW	INJURY OCCUP	RED
ву Р	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY M	WORK?			
ED B	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home building, atc. (Specify)	, farm, street, factory	office	281. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
	4 Homicide determined				,	
PLI	29a. CERTIFIER (Check only   1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death	occurred at the time	, date and place, end dua t	o the cause(a) and m	nner as stated.	
COMPLET	one) 2 🔀 MEDICAL EXAMINER: On the basis of examination and/or inve	estigation, in my opin	ion, death occured at the t	ime, data and placa, a	nd due to the o	:suse(a) end manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMI	BER	29d. DATE S	IIGNED (Month, Day, Year)
TO B	John Go Sulkely, M.T	D.M.E.	D03599		06	-03-95
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2		_			
	John T. Bulkeley, M.D., 108 Pine E	Bluff Road	d, Salisbur	y, MD 218	01	
	31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE					
	31. DATE FILED (Month, Day, Year)  32 REGISTRAR'S SIGNATURE  JUN 05 1995  July Divulence Acids	Ц				



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

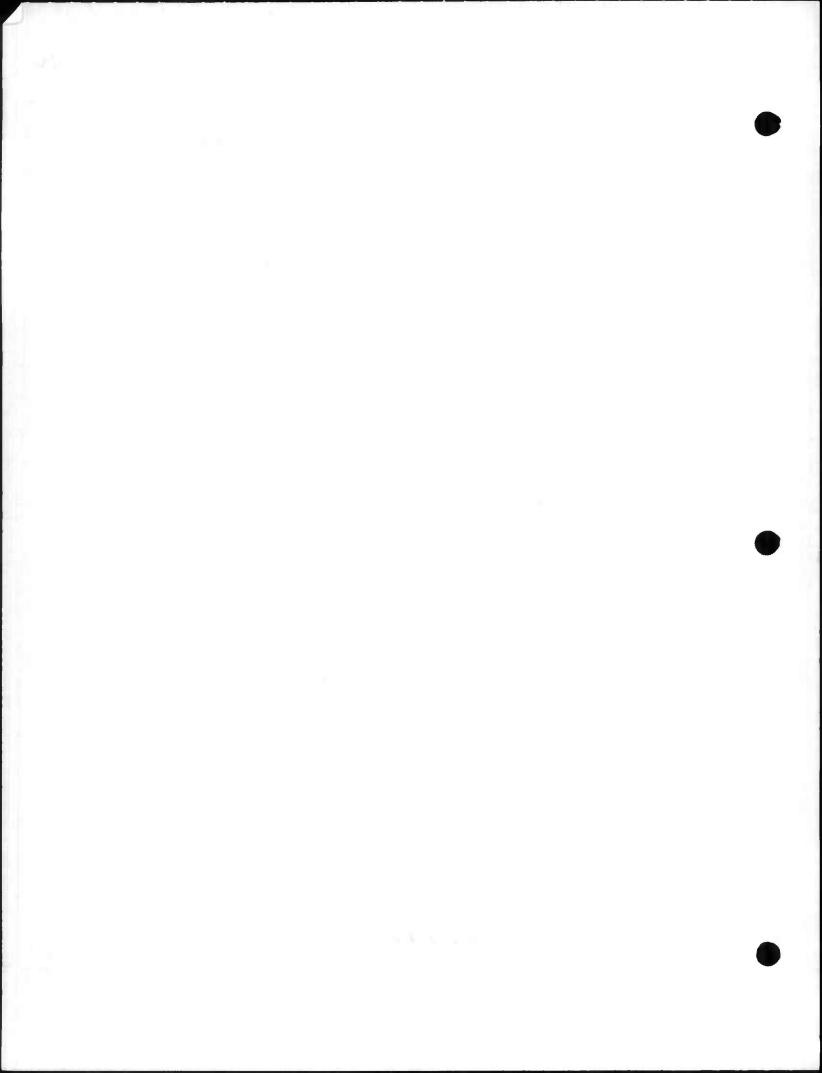
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TE .	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HY	GIENE
STRAR	CERTIFICATE OF DEATH REC	G. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	IEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)  TUHN	JOSEPH			eele	2. DATE OF DEATH DO MONTH DO M	AV VE	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER  186 - 18 - 2801	1 ( M 2   F	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 26, 1	8. 5	BIRTHPLACE (State or Foreign Country)		
TOR	90. FACILITY NAME (If not institution, give : PENINSULA REGION RESIDENCE OF DECEMENT		ENTER		ISBURY	EATH	9c. COUNTY WICO			
DIRECTOR	10a. STATE 10b. COUNT	ussex	10c. C/1	Y, TOWN OR LOCAT			10d. INSIDE CITY LIMITS?  1 YES 2 K NO			
FUNERAL	100. STREET AND NUMBER RD. 3, Box 3050,	Road 514		100	ZIP CODE	6		OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 XWidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DO WW	2 NO	13. WAS DEC						
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	Cation ocompleted)  College (1-4 or 5+) 2				Texaco	SINESS/INDUST	RY		
	17. FATHER'S NAME (First, Middle, Lest) Stewart	Steele			18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)			
TO BE	190. INFORMANT'S NAME (Type/Print)  John S. Steele	Steele			nd Number or Rural	Route Number, City or Town	n, State, Zip Cod	•)		
	20e. METHOD OF DISPOSITION  1 □ Burlel 2 [XCremetten 3 □ Rem	20b	.PLACE AND DATE	OF DISPOSITION (Na	me of		CATION — City	or Town, State		
	4 Donetion 6 Other (Specify)		alisbury		D ADDRESS OF FA	CILITY		, MD 21801		
L	· WICK	alley	2	50	Snow H	uneral Home ill Rd., Sa	lishur	y, MD 21801		
	23. PART I. Enter the diseases, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heert failure. Liet only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Duy To (OR AS A CONSEQUENCE OF):									
z		DUN TO (OR AS A	CAMOUATA	n: Luan	t Farly	W		YRS		
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. Chrisco Due to (OR AS A c. Sechemon	CONSEQUENCE O	myrpall	ý.			YAS		
CERTIFICATION	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F): / / /						
AL	PART II. Other algnificant condition	ne contributing to deeth b	ut not reaulting	in the underlying	g ceuse given in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?		
4: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YI	S I NO I	LINCERTAL			1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO		28. PLACE OF DEA	TH (Check only one) OTHER:						
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b, TIM	E OF 28c. INJ	URY AT RK?	6 Other (Specify) 28d. DESCRIBE HOW IF	NJURY OCCURE	D		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	At home, term,		ES 2 NO	281. LOCATION (Street e City or Town, Stete)	and Number or Ri	urel Route Number,		
COMPLET		ICIAN: To the beat of my knowl	edge, death occurr	ed at the time, date	end place, and due	to the ceuse(s) end men	ner es stated.			
		R: On the basis of examination			eath occured at the	time, date end place, en	d due to the cau			
ro BE	30. NAME AND ADDRESS OF PERSON WH	. aun so			D/C	5688	DATE SIG	NED (Month, Day, Year) -30 -95		
	DONACO M	WOOD MA	PRI							
	31. DATE FILED (MORRIN, Day, Year) MAY 31 1995	32 AEGISTRAR'S SIGN	ar hardell					16.3		

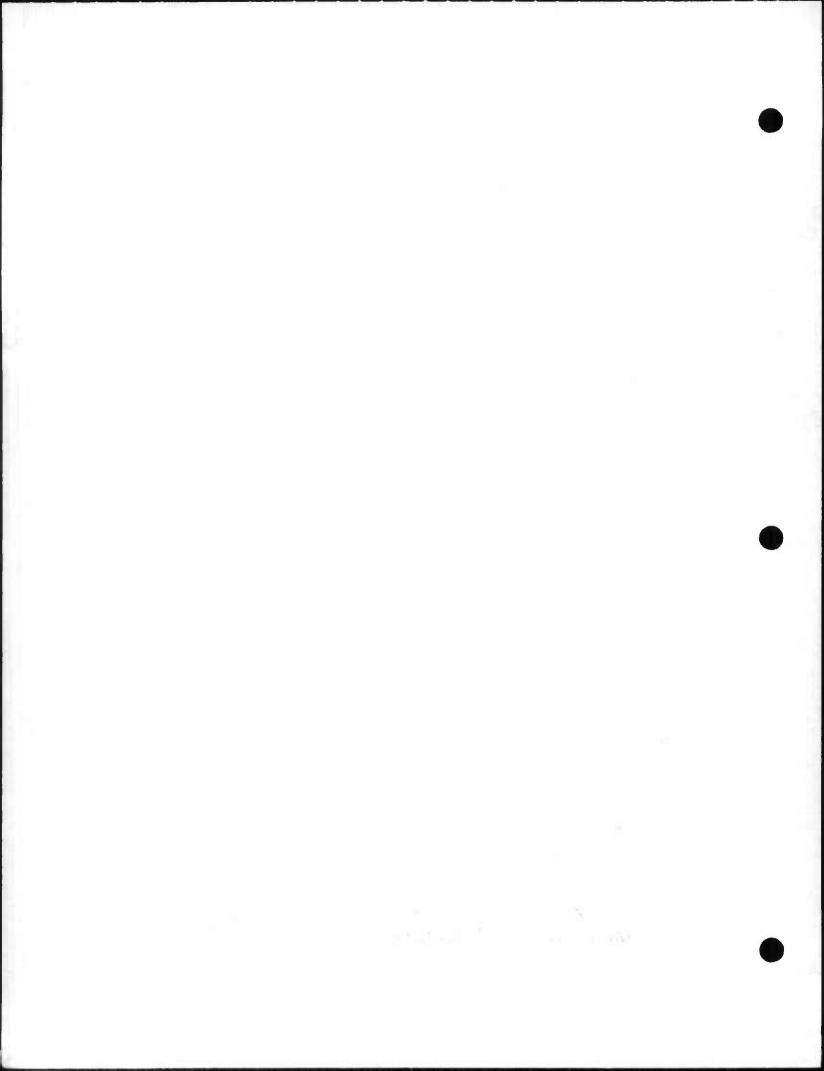


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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  IRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages burs after death with the State Dept. of Heath and Mental Hygiene prior to burlal, cremation, or removal.  28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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95 18679 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	ROBERT	L		STANTON			May 17, 1995			YEAR	3. TIME OF DEATH 10:00 a M
	4. SOCIAL SECURITY NUMBER 235-48-8239	5. SEX 8. AG	E (In yrs. lest		UNDER 1 YEAR OF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) May 8, 1933		- 1	Country			
NC.	98. FACILITY NAME (# not institution, give s 1210 Market St.			9b.		or Location of to		7 8, 1933	9c. COUNT Word	TY OF D	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  Maryland  Worcester			10c. CITY, TOWN OR LOCATION Pocomoke City						T	10d, INSIDE CITY LIMITS?
RAL	10e. STREET AND NUMBER		10f. ZIP CODE						EN OF W	1 X YES 2 NO	
FUNERAL	1210 Market St.  11. MARITAL STATUS	IN U.S. ARI	3. ARMED 13. WAS DECENDENT OF H							— American Indian, , White, atc.	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	S 2 N DATES	NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:						Specifi B		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)    2			e kind of work Do NOT use ret aborer	done durina m	ON ost of working	16b	. KIND OF BUS		STRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) Willie	Henderso	n			16. MOTHER'S N	AME (First, I	Middle, Maiden	Surname)	knov	wn)
TO B	19e. INFORMANT'S NAME (Type/Print)  Karen Guerreo		19b	100 E	RESS (Street	end Number or Rurel coll St.	, Sal	isbury	n, State, Zip (	2 180	01
	20a. METHOD OF DISPOSITION 1 □ Suriat 2 ☒ Cremation 3 □ Ram. 4 □ Donation 6 □ Other (Specify)	oval from State C		NDDATE OF DI			DAT 5/	4	alisb		vn, Stata , MD 21801
21. Signature of Funeral Service users    Salisbury Crematory   5/19								hor	v.MD 21801		
VTION	MMEDIATE CAUSE (Final bleefiles or condition resulting in death)   Due to (or as a consequence of):    Sequentially list conditions, if any, isoding to immediate   Due to (or as a consequence of):										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  d.										
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
MEDICAL					PERFOR  1 \[ \text{YES 2} \]						AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Strain Str										
HYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou 28a. DATE OF INJURY	,		Nursing Hor	ne 5 Residence	7		LIURY OCCI	IRED.	
B	1 Natural 5 Pending (Month, Dey, Year) INJURY 2 Accident Investigation				M 1 🗆	YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED				
ETE	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Ro City or Town, State)							oute Number,			
COMPLETED	29a. CERTIFIER (Chock only one)  2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  2 MEDICAL EXAMINER: On the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
TO BE	29c, LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 29c, LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)								(Month, Day, Year)		
	30. NATURE WHO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (7/10), Protes  20 B 10 R Renew Cle DV Sales Buy . N.J.										
	MAY 31 1995	Jalia davel	sor Ra	Sall				0			



BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAM. The law requires that the death certificate be executed within 2 nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR 1.0 - 0.0									
	4. SOCIAL SECURITY NUMBER					1 199	A			
			(In yrs. lest birthday)	IF UNDER 1 YEA MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		BIRTNPLACE (State or Foreign Country)		
	221-03-5335  Sa. FACILITY NAME (If not institution, give s		103 YRS.			10-7-18		SA-Delaware		
ا <u>س</u> ا				N OR LOCATION OF D	DEATH	9c. COUNTY				
5	1203 Old Telegraph Rd. Warwick Cecil							:11		
E I	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
ā	Maryland Ceci	arwich	2			LIMITS? 1 YES 25 NO				
AL	10a, STREET AND NUMBER		1/4	10f. ZIP CODE	OF WHAT COUNTRY?					
띨	1203 Old telec	graph Rd.		21912	SA					
FUNERAL DIRECTOR	11. MARITAL STATUS	N U.S. ARMED	13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— I4. RACE—If yes, specify Cuban, Maxican, Puerto Rican, etc.)				RACE — American Indian, Black, White, etc.			
ВУ	1 Never Married 2 Married  3 Wildowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR I WW T	DATES		ES 2 NO Speci			Specify: White		
	15. OECEDENT'S EDU	11.71 ==	18a. DECEDENT'S	HOUSE COOKE	TION	16b. KIND OF BU	<u> </u>			
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind of a	work done during se retired.)	most of working			tilizer Co.		
립	1.2	College (1-4 or 5+)	Self-E	mplove	ed Bus.C	wner Agr	icultu	re Products		
S S	17. FATNER'S NAME (First, Middle, Last)	-			18. MOTHER'S N.	AME (First, Middle, Maiden	Surname)			
BE C	James T. Shall	lcross			Mary	E. Vande	egrift			
인	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Number, City or Tow	n, State, Zip Cod	(e)		
=	Edwin E. Shall	lcross	1203	Old 1	elegrap	h Rd., War	rwick,	Md.21912		
	20a. METHOD OF DISPOSITION 1 (5) Burlet 2 □ Cremation 3 □ Rem	oval from State	b. PLACE AND DATE	ther place)			CATION — City			
	4 Donation 5 Other (Specify)	- 0	ld Draw	yers (				, Delaware		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY DANIELS & HUTCHISON FUNERAL HOMES									
	* Louis 4	1 Water				ad st., M:				
$\Box$	23. PART I, Enter the diseases, or o	complications that cause	deeth. Do					Approximate		
	shock, or heart failure. List only one and the activities.  IMMEDIATE CAUSE (Final  Onset and Date									
	disease or condition ————————————————————————————————————							one hour		
	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions,  Due to (or as a consequence or):									
¥.	cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF):									
IRI	resulting in death) LAST									
	PART II. Other significent condition	s contributing to death	but not resulting	in the restact	ine seuse elven i	Part i. 24s, WAS AN	AUTORON I			
EDICAL	Far-advanced	arterios	clerosi	S	my couse given ii	PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
EDI						1 _ YES 2	ZNO	DF DEATH?		
Σ	DID TOBACCO USE (	CONTRIBUTE TO	CALISE OF	DEATH	YES IT NO		- 1	1 YES 2 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	nationt 3 00A	OTHER:	ome 5 Rasidence					
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. T(M	E OF 28c.	NJURY AT	28d. DESCRIBE NOW I	NJURY OCCURE	ED		
ву Р	1 Netural 5 Pending	(Month, Day, Year)	IN.		WORK? YES 2 NO					
	3 Suicide 8 Could not be	3 Suicide 28s. PLACE OF INJURY — At home, farm, stree					OCATION (Street and Number or Rural Route Number,			
COMPLETED	4 Nomicide determined building, atc. (Specify)									
PE	29a. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated,									
MO	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.									
EC	296. SIGNATURE AND TITLE OF CERTIFIE		29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year)				
0	Wallace Obenshain m.D.				D07/29			→ may 3/, 1995		
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	Dr. Obenshain, Chesapeak Family Practice, cecilton, Md.									
	31. DATE FILED (Month, Day, Year)  ALIN 2 1995  FILED (Month, Day, Year)									
1	#19# W 1227	Juna annual								

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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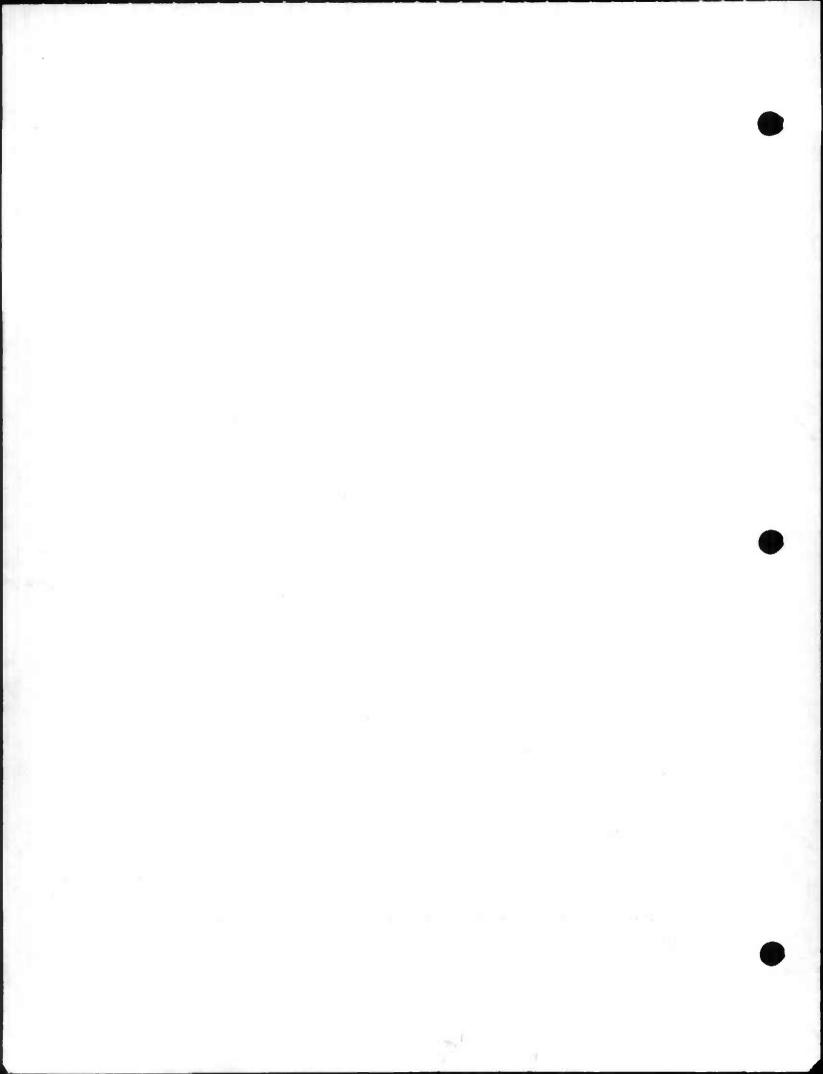
												9	5	1868	
	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAR					MENTAL					
	1. DECEDENT'S NAME (First, Mic	ddle Last)	_		ENTIF	ICATE	· UF	DEA	In		REG. NO				
	WILLIAM SEELEY								MONTH			YEAR	3. TIME OF DEATH	Δ.	
					est birthday)	IF UNDER	1 VEAR	IF UNDER	24.600		) AU :	27, 1		PLACE (State or Fore	[7 M
	198-20-1822		M 2 D F	67	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	Day Year)	1027	Countr	y)	eign
	9a. FACILITY NAME (If not institu	- 07	2.00	9h CITY	TOWN	OR LOCATI	ON OF DE					York			
Œ	Washington Ad	dventi	st Hoer	ital				Park		-2111		1745			
티	RESIDENCE OF DECE	71001		Idk	Ollia	lair				MOI	ntgom	ery			
DIRECTOR		b. COUNTY			10c. CIT	Y, TOWN O	R LOCA	TION						10d, INSIDE CITY	
ō		Prince	George	s	Нуа	attsv	i11	e						1 📉 YES 2 🗌 N	40
FUNERAL	10e. STREET AND NUMBER						-	f. ZIP CODE						HAT COUNTRY?	
W	6006 39th Pla							20782					.A.		
5	11. MARITAL STATUS  1 Never Married 2 Never Married 2	rried 12	FORCES? 1	TEVER IN U.S. A	RMED NO	13. 1	WAS DEC	CENDENT C	OF HISPAN	HC ORIGIN	(Specify Yes	or No—		- American Indien	n,
BY	3 Widowed 4 Divorced	AR OR DATES				2 X NO					Speci	White			
	15. DECEDE	NT'S EDUCAT	ION	16a. D	ECEDENT'S	USUAL OC	CUPATI	ON		165	KIND OF BUS	EINESS /INI	Merny		
E	(Specify only hig Elementary/Secondary (0-12)		npleted) College (1-4 or 5 -		Give kind of le. Do NOT u	work done o	during mo	ost of working	19	1	KIND OF BO	JII4E3371141	J031111		
7						nics	Eng	ginee	er	P	rivate	2			
COMPLETED									ME (First, M	IE (First, Middle, Maiden Surname)					
BE C	William Morgan Seeley Iva Strauss														
2	19a. INFORMANT'S NAME (Type/	,									er, City or Tow				
٦	Beverly Seele	ey		6	006 3	9th	P1a	ce, H	lyatt	svil	le, Ma	aryla	ind 2	0782	
,	26a. METHOD OF DISPOSITION 1 M Burlal. 2 Cremetion 4 Donation 5 Cher (Sp.	3 🗌 Remove	I from State	206. PLACE Cemetery, C. MD V 6	AND DATE	OF DISPOS	eme	meol terv	06/0	DATE	Che		City or To	wn, Stata Maryland	
	21. SIGNATURE OF FUNERAL SI	ERVICE LICEN	SEE	4 A		22.	NAME A	ND ADDRE	SS OF FA	CILITY	- Jone.	LCCIII	iam,	e, P.A.	
	· Clear	les F	: Be	el J		47	39 1	Balti	more	. Ave	., Hya	ttsv	ille	e, P.A. , MD 207	81
	23. PART I. Enter the disea shock, or hear	ses, or com	plications the	t caused the d	leath. Do	not enter	the mo	de of dyl	ing, suci	h aa card	ac or reapl	ratory an	rest,	Approximat	ta
	ahock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final							Oneat and i							
	disease or condition resulting in death)									1400	44				
			our to	(OR AS A CONSI	EQUENCE O	n:	O								
N	Sequantially list conditions	T .		cam	un	al	W	me						100	200
TIFICATION	If any, leading to immediate cause. Enter UNDERLYING														
SE	CAUSE (Disease or Injury														
E	resulting in death) LAST														
CER		C 4.												1	
¥	PART II. Other significent	conditiona c	ontributing to	death but not	reaulting	In the un	derlyin	g ceuse g	given in	Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINE	
8											1 TES 2	NO		COMPLETION OF CAL	
M						1				_	,			1 _ YES 2 _ NO	)
ÿ	DID TOBACCO USE		UTE TO CA				10 E	] UNC	ERTAIN	1 🗆	/			_ : 200	
5	25. WAS CASE REFERED TO ME EXAMINERS		OSPITAL:	26. PL/	CE OF DEA	OTHER	inly one)	_							
The stand of DEATH 28e. DATE OF INJURY (Month, Dey, Year) 29b. TIME OF INJURY WORK? 29d. DESCRIBE HOW INJURY WORK?								8 Other	(Specify)	-					
								NJURY OC	CURED						
B	2 Accident Inve	stigation	28a PLACE O	E IN HIRV At 5	ome from				NO	****					
3 Sulcide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, tectory, office City or Yown, State)							or Rural A	oute Number,							
E	29a. CERTIFIER												_		
<b>WPLET</b>	(Check only			my knowledge, d											
<b>₹</b>			the wests of 61	IO/DUS HOUSEHILL	arvestigatio	n, in my o	pinion, d				ind place, en		/	end manner as stat	ted.
H H	96. SIGNATURE AND TITLE OF	1 A L O C	+24	•				29C LICE	NSE NUM	IBER		294L DAT	E SHONING	(Moren Day, Year)	

3 Suicide 4 Homicide	6 Could not be detarmined	28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)	28t. LOCATION (Street and Numb City or Town, State)
a. CERTIFIER	1		

PERSON WHO COMPLETE CAUSE OF PETH (ITEM 27) (Type, Print)

MARTIN 1525 31. DATE FILED (Morth, Day,
JUN U1 1995 82. REGISTRAR'S SIGNAL

20



DATE OF DEATH

687
BOX
P.O.
RECORDS,
VITAL B
OF
DIVISION

4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthda 7. DATE OF BIRTH (Month, Day, Year)
Jan. 23, IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 244-68-4945 50 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PRINCE GEORGE'S HOSPITAL CHEVERLY 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Temple Hill FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. 2309 Olson Street 20747 retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 XNO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spi (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Bus Driver Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bennie Strong 76 BE Martha Hines notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Linwood Strong/Brother Ridgecrest Drive, Раде 6 тау be pe 20s. METHOD OF DISPOSITION

TO Burisi 2 Cremation 3 Removal from State
4 Donation 5 Dither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must HOMESTEAD MEMORIAL GARDENS 6-4-95 GREENVILLE, CAROLINA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home hours after death. 7474 Landover Road, Landover, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition arismo plustie andy vascular discare lenseur event, resulting in death) DUE TO (OR AS A PONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? After this certificate has been signed by to death with the State Dept. of Health and I any 1 YES 2 NO shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE HEFERRED TO MEDICAL EXAMMER? 26. PLACE OF OEATH (Check only one) Rem HOSPITAL OTHER: YES 2 NO 1 Inpetient 2 ER/Outpetient 3 I DOA 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) 0 27. MANNER OF DEATH 28e. OATE OF INJURY 28b. TIME OF INJURY 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, straet, factory, office building, atc. (Specify) 3 Sulcide DIRECTOR: A 8 Could not be 28 4 Homicide detarmined COMPLET hours 1 CESTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piecs, and due to the cause(a) and manner as stated. (Check only one) THE HOSPITAL THE FUNERAL I TO THE FUNERAL IDE filed within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(a) and manner as stated. BE 2

Davidson Rand

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

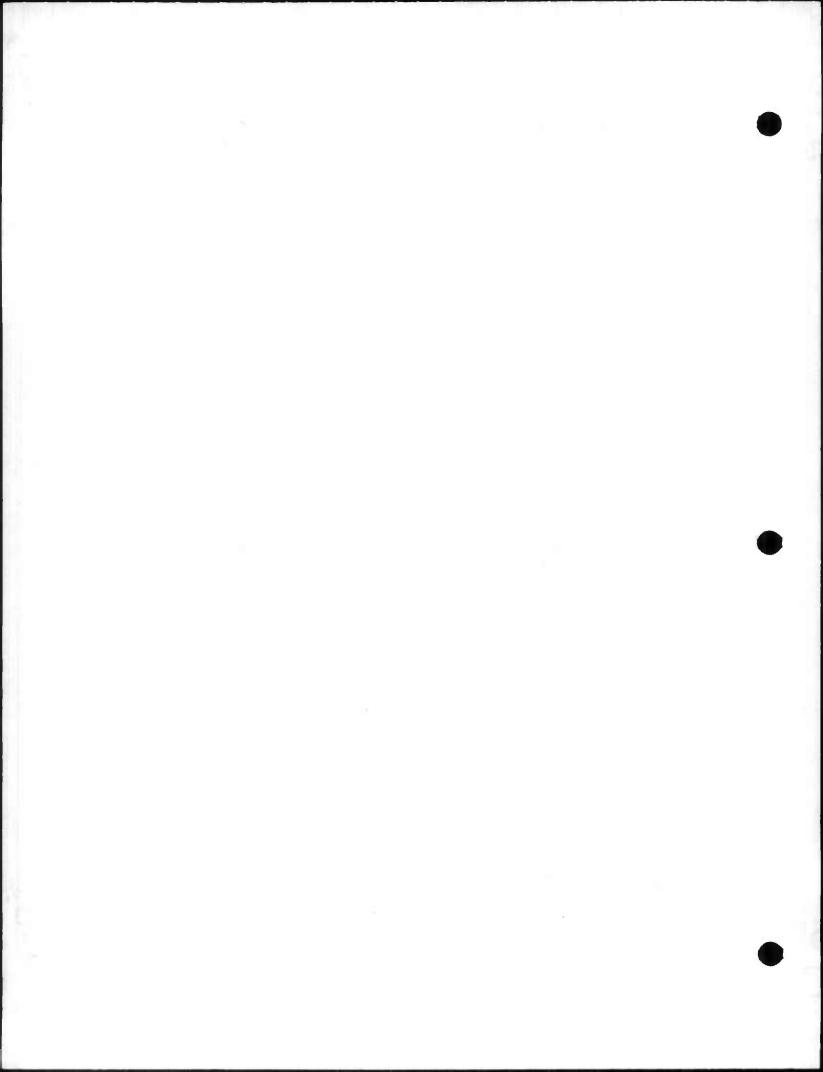
Strong

FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

lie Edward

8. BIRTHPLACE (Stein North Carolina 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, atc. Specify: Black Suitland, Maryland 20c. LOCATION — City or Town, State NORTH 20785 Approximata Interval Between **Onset and Death** 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

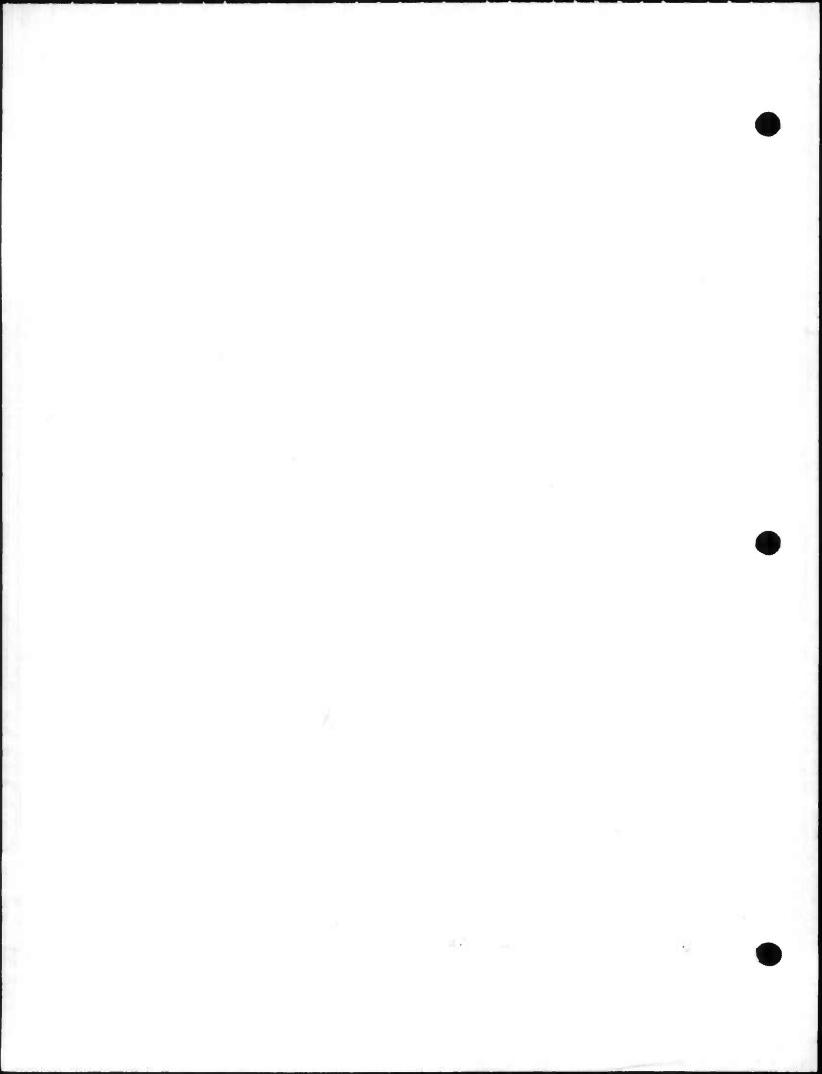
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.										
	1. DECEDENT'S NAME (First, Middle, Last) BARBARA		5	HORTE	R	2. DAT MON MA		5 19	YEAR S	8. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER  579-58-9519  9a. FACILITY NAME (If not institution, give s								Country)	ACE (State or Foreign	
DIRECTOR	Fort Washingto	ngton Medical Center Fort Washington PRINCE GEORGES									
L DIRE	District of Co		TOWN ON ESCATION								
FUNERAL	3510 18th Stre		101						at country? States		
ВУ	11. MARITAL STATUS  1 X Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	2 NO	If yes, sp	AS DECENDENT OF HISPANIC ORIGIN? (Specify Yee yee, specify Cuben, Mexican, Puerto Rican, etc.)  YES 2 X NO Specify:			or No—	Specify:	- American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12th						La	siness/ino	USTRY		
	17. FATNER'S NAME (First, Middle, Last) Pete Short	ter		<u> </u>	18. MOTNER'S N.	Mar (First		Surname)			
TO BE	19e. INFORMANT'S NAME (Type/Print)  19e. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)  1002 Marcy Ave. #204, Oxon Hill, Md. 20745										
									- City or Town, State		
	21, SIGNATURE OF FUNERAL SERVICE LIC	Stewar	+M	STEW	ADDRESS OF FA VART FU Benni	NER	AL HON	1E			
CERTIFICATION	Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory streat, shock, or heart failure. List only one cause on each line.  Approximate interval Batween Onest and Death of the second of the complication of the second of the cause of the										
MEDICAL CE	PART II. Other significant condition PRIOR CEREBROYA					Part 1.	24a. WAS AN PERFOR	MED?	A C	TERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN?  YES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONT		F DEATH YES		UNCERTAI	N 🗆					
IYSIC	EXAMINER?  1 YES 2 NO	HOSPITAL:	atient 3 DOA 4		5 - Residence						
ВУ РН	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME (		RK?	26d. DI	EŞCRIBE NOW I	NJURY OCC	URED		
	3 Suicide 6 Could not be determined	ret, fectory, office		261. LO	CATION (Street of yor Town, Stete)	end Number (	or Rural Rou	ite Number,			
COMPLETED		CIAN: To the best of my knowledge: On the bests of exemination								nd manner ee stated.	
H	29b. SIGNATURE AND TITLE OF CERTIFIER  Scripes MD (DMO)				29c. LICENSE NUMBER			29d. DATE SIGNED (Month), Day, Year)  May 27, 1995			
10	30. NAME AND ADDINGS OF PERSON WN  J, BERGETZ MD		ATH (ITEM 27) (Type, Pr WISCO)		Tue E	BeTh	esda	. Mo	1 2	0874	
31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  33. 1995  34. REGISTRAR'S SIGNATURE											

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dent, of Health and Mental Househ point to burlat, cremation, or removal	HENDERNY, IS less 10 is marked as from 29 should not inline as able to marked the marked to make the could be
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
	Margaret Mae		Sher1	in			1995		12:32 A M
	A CONTRACTOR OF THE PROPERTY O	6. AGE (In yrs. les		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI	PLACE (State or Foreign
	252-05-0978 1□ м 2 🔀 ғ	81	YAS.	INCHINS DAYS	HOURS MIN.	May 29,	1913	Geo	
~	Ba. FACILITY NAME (If not institution, give street and number)				OR LOCATION OF DE	ATH	9c. COUR	NTY OF O	ATH
DIRECTOR	Washington Adventist Hospital Takoma Park Montgomery								
1 11	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TON				10d. INSIDE CITY LIMITS?
	Maryland Prince George	t s	Нуа	ttsville	:				1 X YES 2 NO
₹	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITI	ZEN OF W	HAT COUNTRY?
Ä	4024 Hamilton Street			2	0781		U.S	.A.	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced  12. WAS DECEDENT FORCES? 1   FYES, GIVE WI	YES 2 X	MED 10	I1 yes, spi	ENDENT OF HISPAN acity Cuban, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No—	14. RACE Black Specif	- American Indian, White, etc.
6	15. DECEDENT'S EOUCATION (Specify only highest grade completed)	16a. DE	CEDENT'S	USUAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/IND	USTRY	
H	Elementary/Secondary (0-12) College (1-4 or 5 +	life.	Do NOT us	work done during mose retired.)	st of working				
A P	12	C16	erk T	ypist		Bureau	of S	tanda	ards
TO BE COMPLETED	17. FATHER'S NAME (First, Middle, Lest)  Edward Thompson					ME (First, Middle, Maiden ner Hughe			
BE	19a. INFORMANT'S NAME (Type/Print)	- 40		1000000 101					
2	Grover C. Sherlin					Hyattevi			land 20781
8	20a. METHOD OF OISPOSITION			OF DISPOSITION (Na			CATION —	-	
	1 💢 Surial 2 Cremation 3 🗆 Removal from Stata 4 🗆 Donation 5 🗆 Other (Specify)	comoton, are	materia e	thee places				,	d, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Iwasiii	iigtoi		ID ADDRESS OF FA		J 3u1	LIAII	u, Maryland
	N. B. C.					s Sons Fu			
-	23. PART I. Enter tha diseasea, or complications that	coursed the de	oth Do a	4739 B	altimore	Ave., Hy	attsv	ille	, MD 20781
	ahock, or heart feiture. List only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Myocar	rdial Fa	ailur	·e	ue or cynig, auc	r as cardiac or reap	mretory arr	eat,	Approximata Interval Between Onset and Daath < 24 hrs
5			10.0078-70	F):					
N N	Sequentially list conditions,	Stenos		า:					> 1 yr
¥	cause. Enter UNDERLYING			,					i l
Ĕ	that milliance profits	OR AS A CONSEC	DUENCE OF	<b>ጉ</b> :					
CERTIFICATION	resulting in death) LAST								
	PART II. Other algnificant conditions contributing to	death but not r	eeulting i	n the underlying	ceuse given in	Part I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL	Status Post Aortic Val					PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
9						1 YES :	Z (S NO		OF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAL	JSE OF DEA	TH YE	S I NO M	UNCERTAIN	<u>-</u> -			1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	011021111				
SIC	EXAMINER?  1 YES 2 NO 1 IN Inpatient 2	ER/Outpatient 3	□ DOA	OTHER:	5 🗆 Rasidenca	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH  1 Naturel 5 Pending		28b. TIM INJ	E OF 28c. INJU	JRY AT	28d. DESCRIBE HOW	INJURY OCC	URED	
B	2 Accident Investigation	IN HIDY At ho		m 1 Y	ES 2 NO	201 1 000 100 100		0.10	
COMPLETED	3 Suicide 8 Could not be building, a determined	tc. (Specify)	nro, tarrii, 1	mreet, factory, ornea		261. LOCATION (Street City or Town, State)	and Number	or Hurel Ho	oute Number,
F	200. CERTIFIER COMPANY OF THE PROPERTY OF THE	ny knowledge, de	ath occurre	ed at the fime, data	and place, and due	to the cause(a) and ma	nner as state	ıd.	
OM	MEDICAL EXAMINER: On the basis of axe								and manner as stated.
	296. SIGNATURE ANGETTIE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE	SIGNED (	Month, Day, Year)
) BE	1111				1288	783	▶ <sub>M</sub>	av 2	7, 1995
10	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	E OF DEATH (ITE	<b>4 27)</b> (Туре,	Print)	U. C. U O	0	I I'll	ay Z	1 1777
	Anium Oazi, M.D. 1706	New Hami	oshir	e Ave	N.W. Wa	shington,	D.C.	20	009
	31. DATE FILED (Month, Day, Year) 32. REGISTRAN	'S SIGNATURE							
	MAY 31 1995 Julia Studion Ra	1004							

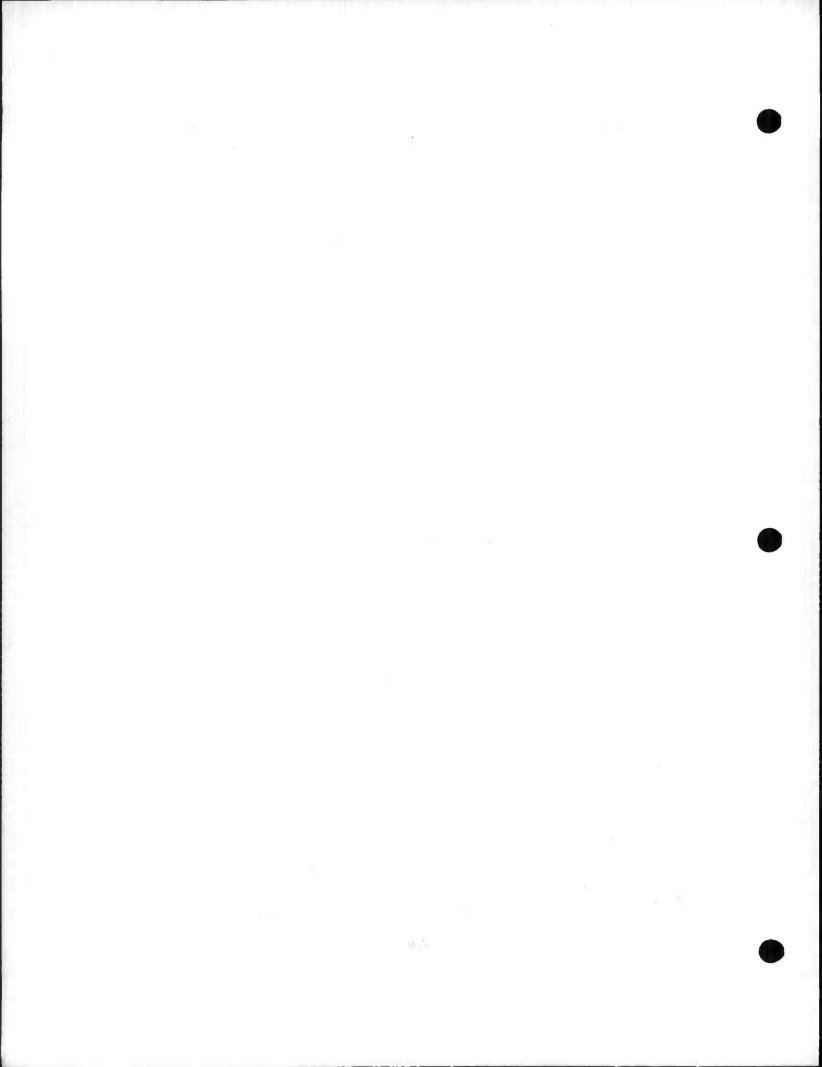


BALTIMORE, MARYLAND 21215-0020

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DIVISION	- 6
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE C	OF DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)		50-1			2. DATE OF DEATH	2. DATE OF DEATN 3.		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	In yrs. last Virthday)	r e/		1/ay-16,	1995	- 802 b	
	579-03-5234	1 X M 2 □ F	78 YRS.	IF UNDER 1 YEA	78 HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 20,		Country)  Augusta G	
OR	90. FACILITY NAME (If not institution, give s Southern Maryl		al		or location of de nton,	EATH		y of DEATH ICE George	
딦	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNT	Υ	10e CIT	Y, TOWN OR LO	CATION			1	
DIRECTOR	Maryland Pri	nce George		linton				10d. INSIDE CITY LIMITS? 1 X YES 2 N	
FUNERAL	9015 Cameron C	Court			101. ZIP CODE 20735		10g. CITIZE	N OF WHAT COUNTRY?	
ВУ	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D	U.S. ARMED 2. JAIO ATES 2	If yes,	DECENDENT OF NISPAN, apecify Cuben, Mexica YES 2 NO Specify		or No 1	RACE — American Indian Black, White, atc. Specify: Black	
LED	15. DECEDENT'S EDU- (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUP	ATION I most of working	16b. KIND OF BU	SINESS/INDUS	STRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us Cha	oo rotirod.) auffer	most of working	Pepco			
Ö	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)		
BEC	Unknown				Unkno		·		
10 E	190. INFORMANT'S NAME (Type/Print) Karen Russell		9015	Camer	on Court	oute Number, City or Tow	n, State, Zip Ci n, MI	20735	
	20a METNOD OF DISPOSITION  Burlel 2 Cremetion 3 Rem	cupi from State	PLACEANDDATE	OF DISPOSITION	(Name of	DATE 20c. LO	CATION — CI	y or Town, State	
	4 Donation 5 Other (Specify)	F Cam	t. Lind	ther place)	Cemetery	5-22 Br	entwo	ood. MD	
	21. SIGNATURE OF FUNERAL SERVICE INC	SPISEE ()	1	22. NAME	E AND ADDRESS OF FA	Stric	kland	Services	
	the /V	Street	and	9507	Silver	Fox Turn	, Cli	inton, MD	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								
_	PART II. Other algnificant condition	s contributing to death b	ut not resulting	in the underly	vina causa aluna in	Dod! las uno su	44177277014		
EDICAL	Ethupliam.	segue de		Zie andani	and caned diseit in	PERFOR	MED?	24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAL	
		0	V P OV - V			1 YE\$ 2	MO NO	OF DEATH?	
2	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S I NO	☐ UNCERTAIN	IM		1 YES 2 NO	
CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	TH (Check only o					
PHYSICI	1 1 VES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outp	etlent 3 🗆 OOA	OTHER: 4 - Nursing N	iome 5 🗆 Residence	6 Other (Specify)			
ВУ РНУ	27. MANNED OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 26c.	INJURY AT WORK?  YES 2 NO	26d. DESCRIBE NOW II	NJURY OCCU	RED	
60	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, e	street, factory, o	ffice	261. LOCATION (Street of City or Town, Stelle)	and Number or	Rural Route Number,	
COMPLET	29a, CERTIFIER	CIAN: To the heat of my leave	adaa daath aanum	d of the time of	late end place, and due	to the cause(e) end men	ner as stated,		
	(Check only								
8	(Check only 1 CEBNI-YING PNYSH one) 2 MEDICAL EXAMINE	R: On the basis of examination							
BE	(Check only	R: On the basis of examination				lime, date end place, en	d due to the c		
ш	(Check only 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the basis of examination		n, in my opinior	n, death occured at the	lime, date end place, en	d due to the c	euse(e) end manner ee stat	
BE	(Check only 2 MEDICAL EXAMINE 296. SIGNATURE AND TITLE OF CERTIFIER 30, NAME PAID ADDRESS OF PERSON WH	R: On the basis of examination	ATURE	n, in my opinior	n, death occured at the	lime, date end place, en	d due to the c	euse(e) end manner ee sta	



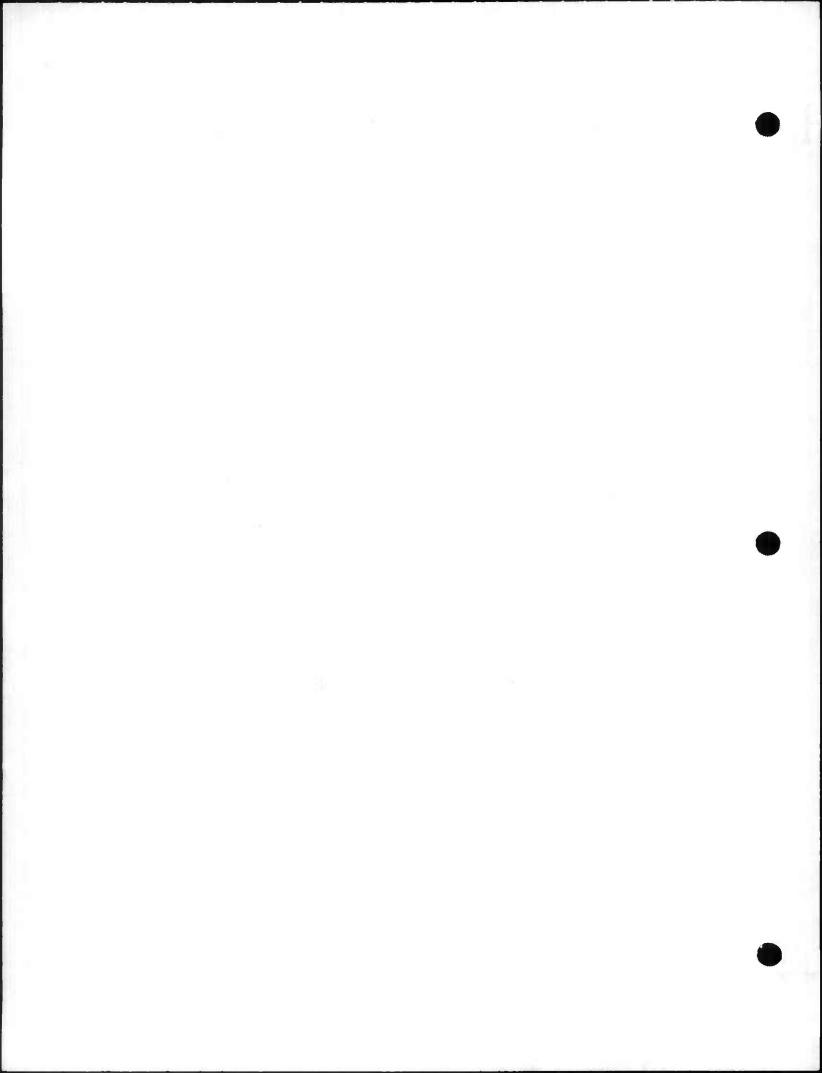
1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						OLIII	HIOAI	_ 01	DEA	111	-	HEG. NO.			
		1. DECEDENT'S NAME (First	The Party and								2. DATE OF MONTH	DEATH		YEAR	3. TIME OF DEATH
		ADDIE LO		SHEPPAR							May	25	19		11:05 p M
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (I	in yrs. lest birth	MONTHS	DAYS	IF UNDER	MIN.	7. DATE OF (Month, Di	BIRTH by, Year)		8. BIRTHE	PLACE (State or Foreign
목		579-62-008		1 M 2 🕸 F		48 Y	rs.		1.00.10		L		946	Sout	h Carolin
3 should	Œ	90. FACILITY NAME (If not it					96. CIT	Y, TOWN	OR LOCATI	ON OF DI	EATH		9c. COUN	ITY OF DE	HTA
6,	20	Suburban	Hosp:	ital			Be	the	sda				Mon	tgom	nery
Pages 1	REC	10e. STATE	10b. COUNTY			100	CITY, TOWN	OR LOCA	TION						10d. INSIDE CITY
<u></u>	ā	MD.	Monto	omery			aith	ersi	hura						LIMITS?
permit.	A	10e. STREET AND NUMBER							H. ZIP COD				10g. CITIZ	ZEN OF WI	HAT COUNTRY?
020 physician. burlal-transit	FUNERAL	20512 Far	croft	Lane					208	82			1	U.S.	Α.
020 physician, burlai-trar	글	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES	U.S. ARMED	13	WAS DE	CENDENT (	OF HISPAN	NIC ORIGIN? (9 in, Puerto Rica	pecify Yea o	or No	14. RACE Black.	- American Indian, White, atc.
5-0020 nding physic is the burial	B	3 Widowed 4 Dive		IF YES, GIVE Y	WAR OR DA	TES						,,		Specify	
- 6 '4	0	15. DEC	EDENT'S EDU	CATION	Т	16e. DECEDE	NT'S USUAL	OCCUPATI	ON		165 KII	ID OF BUSIN	MESS (IND)		Black
2 9 2		(Specify onli Elementery/Secondary (	y highest grade	College (1-4 or 5	4)	(Give kin	d of work done OT use retired.	during me	ost of worki	פר	100.10	0. 000	1000/110	OJIMI	
ND hospital ached fo	길量			4yrs	"	Reco	ords	Mana	ager			D٣	ivat	- 0	
detac	COMPI	17. FATHER'S NAME (First, M	liddle, Last)								ME (First, Midd				
2 2 2	is III	Clarence		s, Jr.					Ad	die	Smit	h			
MAR retained 5 should	TO B	190. INFORMANT'S NAME (		West Williams		19b. MA	LING AODRE	SS (Street	and Number	or Rural I	Route Number, (	City or Town,	State, Zip	Code)	
- 2 8	1 00	LeMarque		ard		205	12 F	arcı	coft	Ln	. Gai	ther	sbur	ca.	Md. 20882
r E i	must	20a, METHOD OF DISPOSIT	n 3 12 Reme	oval from State	ceme	PLACE AND D	Or other place	SITION (N	eme of		OATE	20c. LOCA	ATION — C	City or Tow	n, State
		4 Donation 5 Other		ENCEE	-   C	hurch	Cem	etei	CY	*****	6-1	Camde	en,	Sou	th Caroli
ALTIM death. Page funeral dire	a raminer	Mimle	011/1/		1000	-Tor	) J	. B.	Jen	kins	S Fun	eral	Hon	ne	
		Egonac	rige					474	Lan	dove	er Rd	. Lar	ndov	er,	Md.20785
E E	Hedical Hedical	23. PART 1. Enter the d shock, or h	iseases, or c eert fellure. I	ompfications the List only one cet	t caused ise on ee	tha desth.	Do not ente	r the mo	oda of dy	ing, auc	h ss cerdiac	or reapira	tory arre	est,	Approximata Interval Batween
filled on. or	2	IMMEDIATE CAUSE (Fir disease or condition	nal	C 1											Onset and Death
ithin letely emati	1,	resulting in death)	<b>→</b> ,	Scpt	Comi	CONSEQUEN	ncompai	n res	istent	Jh	q-cut	eroc	occi	)	7 days
68/6 ecuted w nd comp bunial. cr	ava ava				(on no n	CONSCIONA	AL OF J.								21/Lyn
esecu and or	ERTIFICATION	Sequentially list condit if any, leading to imme		DUE TO	(OR AS W	CONSEQUEN	E OF):	Jeaj							2.240
Siciar prior	CAT	cause. Enter UNDERLY	ING	SYSH	emic	CONSEQUENC	is ev	the	maj	Losu	15				25 yr
ruffica ng phy giene		CAUSE (Disesse or Inju that initiated events		DUE TO	(OR AS A	CONSEQUEN	E OF):								
Thendir Hy	EH	resulting in death) LAS		1											
at the de by the all and Ment	AL CE	PART II. Other significa	nt condition	contributing to	deeth bu	it not result	ing in the u	nderlyin	g ceuse (	given in	Pert I. 24	. WAS AN AL	UTOPSY	24b. V	WERE AUTOPSY FINDINGS
T w b E	EDICAL	Con sumpher				erteusia						PERFORM			MAILABLE PRIOR TO COMPLETION OF CAUSE
Sign Sign		heart fai						0	/		_   '	YES 2	NO		OF DEATH?
e law requestas been Dept. of 1	W	DID TOBACCO U		RIBUTE TO CA	USE OF	F DEATH	YES 🗆	NO E	UNC	FRTAIN	νП				I NES 2 NO
AN: The law r bificate has be state Dept.	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?				6. PLACE OF					-				
SICIAN: The certificate In the State	YSICI/	1 TYES 2 THO		HOSPITAL:	ER/Outpa	itlent 3 🗆 Do	A 4 Nu		ne 5 🗆 Re	sidenca	6 Other (Sp	necify)			
ATTENDING PHYSICIAN: The law requestions. Safer this certificate has been safer ceath with the State Deet, of	. T	27. MANNER OF DEATH	~%	28a. DATE OF (Month, D		28b	TIME OF		JURY AT		28d. DESCRI	BE HOW INJ	URY OCC	URED	
After the death w	BY P		Pending Investigation				М		YES 2	NO					
TTENDIN TOR: After dea	ا ۾ اه		Could not be	28e. PLACE O building,	F INJURY - atc. (Specif	— At home, fe	rm, street, fe	ctory, offic	:0		28f. LOCATIO City or To	N (Street and wn, State)	d Number (	or Rural Ro	ute Number,
OR ATTENDING DIRECTOR: After hours after death	COMPLETE		ootariiiriot												10/10/
7 K K	MPLE			CIAN: To the best of											
	0	2 MEO	CAL EXAMINE	R: On the beals of e	xamination	and/or investi	gation, in my	opinion, d	Seath occur	ed at the	time, data and	place, and	dua to the	a cause(a)	and menner as stated.
THE H	BE CO	296. SIGNATURE AND TITLE	OF CERTUFIER	0.11	_	4. 17	\		29c. LICE	NSE NUN	MBER 1	12			Month, Day, Year)
225	2	30. NAME AND ADDRESS OF	12.5	schule	u,	NY			DI	LB	17				, 1995
(15		6.	Chechta	COMPLETED CAU	CLA 24	TH (ITEM 27)	Type, Print)	# 5	700	Roll	heidai	110	2	.081	4
(3)		31. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNA	TURE	1 1700	11-0	7 7 1	UCTI	- WAY1	IVIV.			1
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(15)

	1 - FOR STATE OF MARY REGISTRAR		MENT OF HEALTH AND	MENTAL HYGIEN				
	1. DECEOENT'S NAME (First, Middle, Last) SWENTON A.	STRO	MAN, SR.	2. DATE OF DEATH MONTH D.	AY 1995	3. TIME OF DEATH 2:45 DM		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGI $578-80-6864 \qquad 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$		IF UNDER 1 YEAR IF UNDER 24 HRS. NONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT.10.19	7. DATE OF BIRTH (Month, Day, Year)  8. BIRTHPLACE (State or Foreign Country)			
TOR	98. FACILITY NAME (If not institution, give street and number)  5612		96. CITY, TOWN OR LOCATION OF D SEAT PLEASANT	TY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE				
DIRECTOR	10a. STATE 10b. COUNTY  MARYLAND PRINCE GEORGE'S		TOWN OR LOCATION			tod. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 7011 EAST KILMER STREET	LIAN	101. ZIP CODE 207	85	10g. CITIZEN OF USA	WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS  1 X Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER FORCES? 1A YES	8 2 NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic t _ YES 2 X NO Speci	NIC ORIGIN? (Specify Yes	or No- t4. RAG Blo	CE — American Indian, ock, White, atc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  12th	16a. DECEDENT'S U. (Give kind of wo life. Do NOT use INSTA	rk done during most of working retired.)	16b. KIND OF BUS	SINESS/INDUSTRY PVT.			
BE COM	17. FATHER'S NAME (First, Middle, Last)  EARL B. STROMAN			AME (First, Middle, Maiden ETHA AUSTIN				
10 6	190. INFORMANT'S NAME (Typo/Print)  DORETHA STEVENS/ MOTHER	19b. MAILING A 7011 E	CAST KILMER STR	Route Number, City or Tow EET LANDOVI	ER, MD	20785		
	1 \ XBurial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify)	bb. PLACE AND DATE OF imetery, crematory or othe HARMONY ME	DISPOSITION (Name of or place) MORIAL PARK	5-27 LAN	CATION — City or TOOVER, M.			
	* Juanaria de Funeral SERVICE LICENSEE BLA	Who	22. NAME AND ADDRESS OF FU J.B. JENKIN 7474 LANDOVE		HOME DOVER, M	D 20785		
	23. PART I. Enter the diseases, or complications that cause shock, or heart feliure. Liet only one cause on IMMEDIATE CAUSE (Final	eech ilne.		ch se cerdisc or respi	ratory srrest,	Approximats Interval Between Onset and Death		
	disease or condition resulting in death)  a. VENTRIC  DUE TO (OR AS	A CONSEQUENCE OF):	BRILLATION			minutes		
ATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	A CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disesse or injury	A CONSEQUENCE OF):			7			
¥	PART II. Other algnificant conditions contributing to death			Part i. 24a, WAS AN PERFOR	AUTOPSY 24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE			1 O YES 2	[¾NO	COMPLETION OF CAUSE OF DEATH? t YES 2 NO		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH	(Check only one)					
	27. MANNER OF DEATH  1 Netural 5 Pending  28e. DATE OF INJURY (Month, Day, Year)			6 Other (Specify)  28d. DE\$CRIBE HOW II	NJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJUR building, stc. (Sp.	Y — At home, farm, streecify)		28f. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,		
COMPLET	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my kno one) MEDICAL EXAMINER: On the basis of axaminati					s) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER  WHO DIE OF CERTIFIER		DZ59	MBER		(Month, Day, Year)		
TO	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D T. BERGER MD #205, 7726	EATH (ITEM 27) (Type, P. UISCONS	SIN AVE BE	THESDA M				
	MAY 3 0 1995 Julia Davilson Rose							



the hospital or attending physician. ALTIMORE, MARYLAND 21215-0020 Page 6 may be retained by permit. Pages 1, 2, 3

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page 5

director,

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BORODULIA

31. DATE FILED (Month, Day, Year)

MAY 31 1995

WESTOVER, MD.

32 REGISTRAR'S SIGNATUR

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BALII	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing hours after death. P.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Debt, of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examin
n	s after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal.	dical
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	Ĕ	State	Item
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ROBERT CURTIS SMITH PM 05 13:35 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign DAYS HOURS M 2 | F 419-90-3352 YRS. 10/26/62 **ALABAMA** 9s. FACILITY NAME (If not institution, give street and number) 9h CITY, TOWN OR LOCATION OF DEATH DE COUNTY OF DEATH DIRECTOR ECI INFIRMARY SOMMERSET, MD. WEST OVER RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MD. SOMERSET WESTOVER 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? CORRECTIONAL INSTITUTION U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 
YES 22 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 NO BY Specify: 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION CARPENTER 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname, notified at ROBERT WILSON ESSALINE SMITH BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7759 NORMANDY ROAD HYATTSVILLE, DIANE TATE 20785 MD 200, METHOD OF DISPOSITION eq 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE must Buriel 2 Cremetion 3 Re cemetery, crematory or other place)
FIRST BAPTIST CHURCH CEM. 4 Donation 5 Other (Specify) 06/01/95 EUTAW. examiner 22. NAME AND ADDRESS OF FACILITY AAMAN FUNERAL SERVICE WASH., D.C. medical 23. PART & Enter to diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shoc or heart/h hare. List only one couse on each line. interval Batween IMMEDIATE CAUSE (Fine disease or condition **Onset and Death** the resulting in death) MULTI ORGAN SYSTEMS FAILURE event, IMMED. other traumatic DEHYDRATION, ELECTROLYTE IMBALANCE DUE TO (OR AS A CONSEQUENCE OF): WEEKS CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING HIV, CMV
DUE TO (OR AS A CONSEQUENCE OF) YEARS CAUSE (Disease or injury that initiated events resulting in death) LAST 6 any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES X NO OF DEATN? Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) Item 2 HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCUREO 28 Is marked, Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, term, street, tactory, office 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide If Item 29a. CERTIFIER TERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 286. SHANGE AND FITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) B D28769 5/25/95 2 30. NAME AND AGORESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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STATE REGISTRAR

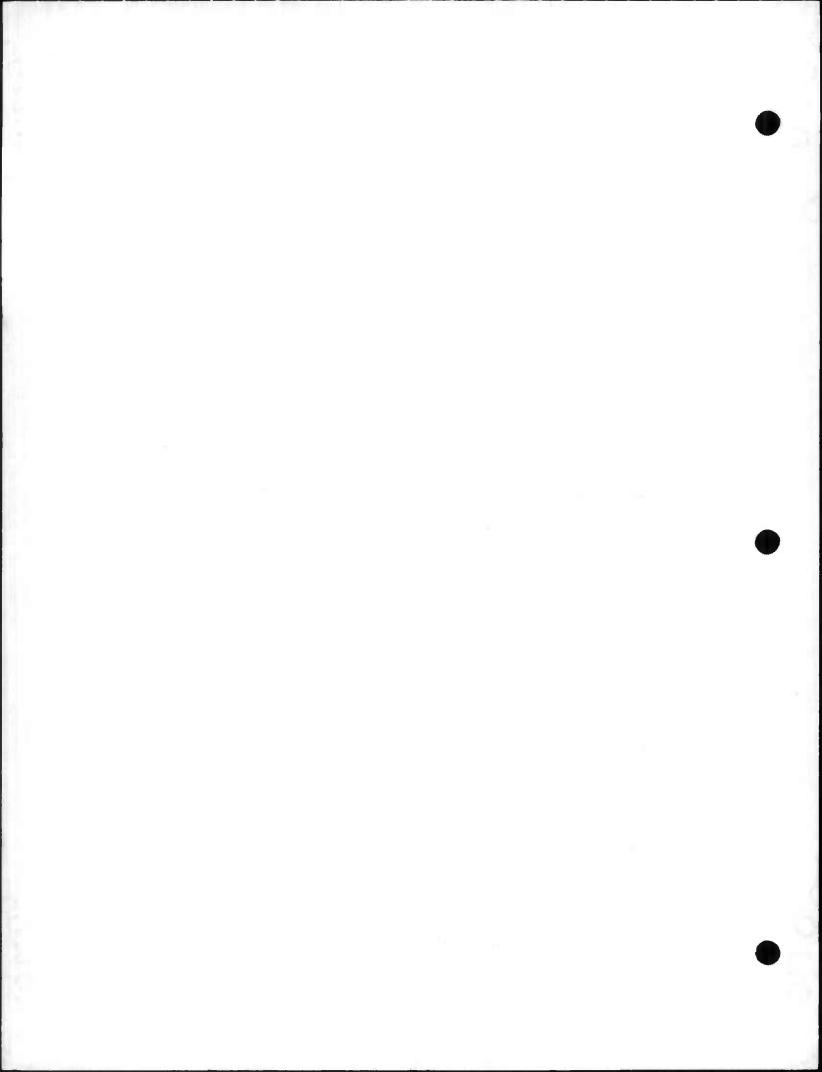
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR SHIRLEY STEPHENS 7:25 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign Country Pittsylvani A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. (Month, Day, Year) 1937 1 M 2 XF 229-48-4051 57 YRS. November 11 County, Virginia permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) oc. COUNTY OF DEATH Prince George's 9b. CITY, TOWN OR LOCATION OF DEATH Prince George's Medical Center DIRECTOR Cheverly County RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION County 10d. INSIDE CITY LIMITS? Maryland Prince George's Capitol Heights 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? AMERICA 10e. STREET AND NUMBER FUNERAL funeral director, page 5 should be detached for use as the burial-transit 11 Tunic Avenue 20027 Inited States of retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2X NO Specify: 1 Never Married 2 Merried BY 3 Widowed 4 X Divorced Black. ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Domestic Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 John Eddie Grastv Lena Fitzgerald BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cheryl L. Stephens 704 Lee Street, Danville, Virginia death. Page 6 may be 9 20g, METHOD OF DISPOSITION
1 [A Burist 2 G Cremation 3 G 20b. PLACE AND DATE OF DISPOSITION (Name of 5/27 Danville, Virginia must Danville Memorial Gardens 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner #M00690 22. NAME AND ADDRESS OF FACILITY Fisher & Watkins Funeral Home, Inc. 707 Wilson Street, Danville, VA 24541 compitately filled in by the fall, cremation, or ramoral. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiag or respiratory arrest, Approximate shock, or heart failure. List only one ca rval Bety 8 IMMEDIATE CAUSE (Final Onset/and Death å disease or condition use event, resulting in death) and con burlat. traumatic CERTIFICATION Sequentially list conditions, 8 If any, leading to immediate prior cause. Enter UNDERLYING CAUSE (Disease or Injury injury, or other resulting in death) LAST The arms Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WENE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY signed by 2 Health and PERFORMED? shows any THE PER EXXNO T YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \text{N}\) UNCERTAIN \( \square\) PHYSICIAN: Pept 23 25. WAS CASE REFERRED TO MEDICAL 36. PLACE OF DEATH (Check only one) the State HOSPITAL 1 YES 1 X NO T ☐ Inpatient 3 ☐ ER/Outp 4 I Nursing Home 5 I Besidence 5 I Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Weer) 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 異な marked. 1 X Statursi 2 Accident 5 Pending м t YES 2 NO BY Affect 25s. PLACE OF INJURY - At home, form, street, factory, office 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) . COMPLETED DIRECTOR: hours after 4 | Homicide 22 29s. CERTIFIER FUNERAL within 72 = TO THE HOSPITA TO THE FUREFAI THE filed within 72 IMPORTANT: # DICAL EXAMINER SHATURE AND TITLE OF CERTIFIER BE 2 31. DATE FILED (Morett, Day, Year, 32. REGISTRAR'S Davidson Rardall 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AND APPROXIMATION OF THE PARTY

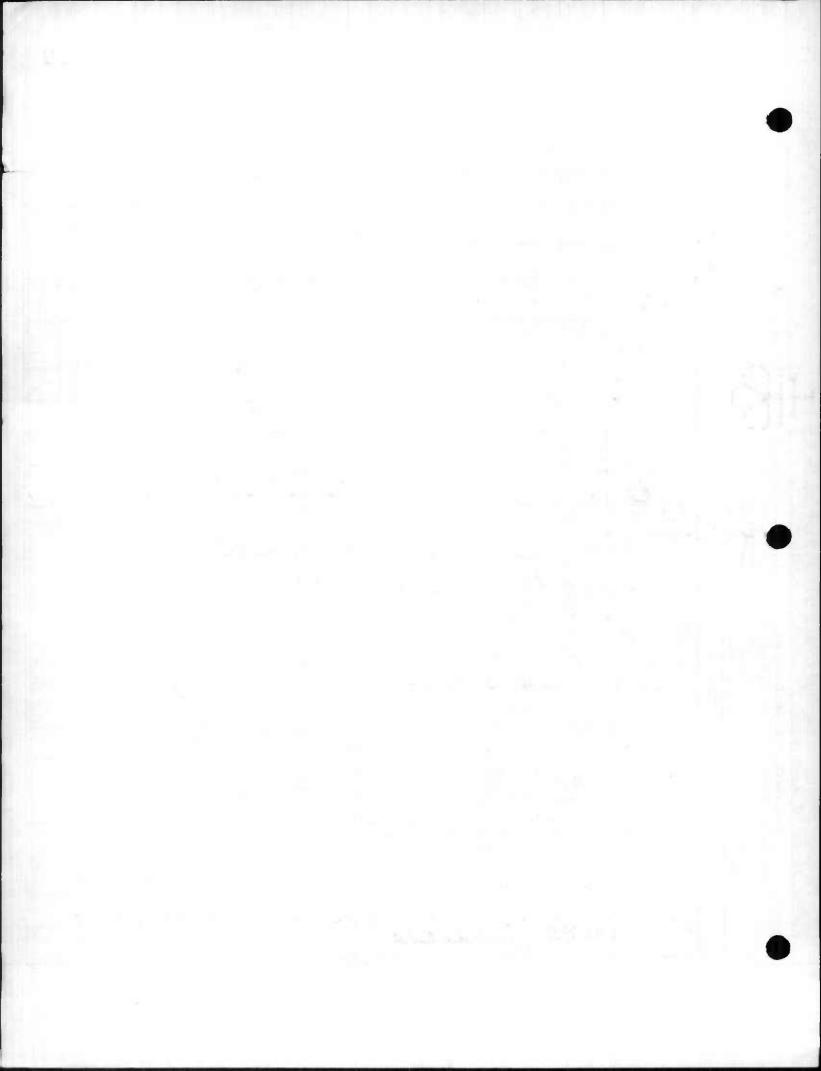
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours are feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove.

IMPORTANT: If them 28 is marked, or item 23 shows eny injury, or other traumatic event, the medical assembler must be notified at once.

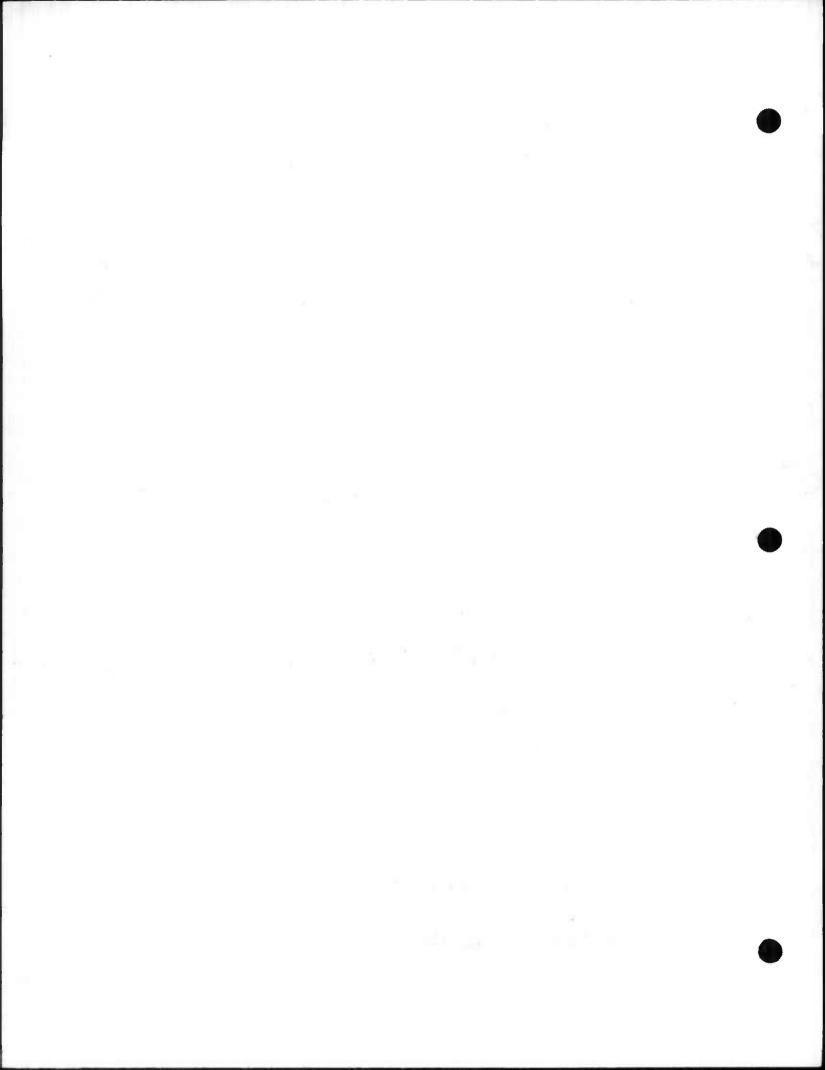
STATE	0F	MARYLAND .	DEPARTMENT	<b>OF</b>	HEALTH	AND	MENTAL	HYG	IENE
		C	<b>ERTIFICATE</b>	OI	F DEAT	TH		REG.	NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTI	MENT OF H	EALTH AND I	MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT		3. TIME O	F DEATH
	Clarence F.					MOUTS	28	95 8:	45 P M
	4. SOCIAL SECURITY NUMBER		Mc	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ye	H ar)	8. BIRTHPLACE (Star Country)	ite or Foreign
	220-00-02-72	1 M 2 □ F 98		WINS CATS	HOURS MIN.	Dec 27		Colorado	
œ	Ge. FACILITY NAME (If not institution, give atm			b. CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUN	TY OF DEATH	
5	Carroll County Ge	neral Hospital		West	minister	144		Carroll	
DIRECTOR	10a. STATE 10b. COUNTY			OWN OR LOCAT	ION			10d, INSID	DE CITY
	MD Cai	rroll		Sykesv	ille			1 TYES	2 X NO
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZ	EN OF WHAT COUN	ITRY?
ÿ	7200 Third Aven				21784		Uni	ted State	S
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN U FORCES? 1 X YES	2 NO	13. WAS DEC	ENDENT OF HISPAN reify Cuban, Maxica	NC ORIGIN? (Speci	ly Yes or No-	14. RACE — America Black, White, atc	en Indian, c.
B≺	3) (Widowed 4 Divorced	1914-1947	ES		2 NO Specify			Specify: With	hite
	15. DECEDENT'S EDUCA	ATION 16	6a. DECEDENT'S US	UAL OCCUPATION	ON .	16b, KIND O	F BUSINESS/INDU		
E	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	(Give kind of world life. Do NOT use n	done durina mo	st of working				
릴		5	Neval	Officer		Unit	ed State	es Navy	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, M	siden Surname)		
BE	Swan A. Swa	กรอก				Emma St	rand		
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural I				
	Clarence F. Swan				St. Sprir				
	20a. METHOD OF DISPOSITION  1  Burial 2 Cremetion 3 Remove	rai from State 20b. PI	LACE AND DATE OF I	place	me of	DATE 20	c. LOCATION — C	ity or Town, Stata	
	4 Donation 5 Other (Specify)	I FO	rt Lincol	n Crem	atory 5/3	31/95	Brentwo	ood, Mary	<u>rland</u>
	1/1/	1		HINE	5 RINA	John M.	Taylor	Funeral mapolis,	Home
_	Mesund. Gr	bellege							MD
	23. PART I. Enter the diseasea, pr co ahock, pr heart fallure. Li	mplications that caused that only one cause on saci	ha death. Do not h lina.	enter tha mo	de of dying, auci	h aa cardiac or :	reapiratory arre		roximate rval Between
	IMMEDIATE CAUSE (Final			/					et and Death
	disease or condition	ONGEST DUE TO (OR AS A CO	IVE H	EART	TAIL	URE		Ye0	245
		DUE TO (OR AS A CO	The bar	V . 11:	4			~	
S	Sequentially list conditions, b.	DUE TO (OR AS A CO	ONSEQUENCE OF	11007	in			16	ers
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		onsessense or j.						
틸	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):						
표	resulting in death) LAST								
	PART II. Other aignificant conditions	contributing to death but	ant condition to a	h					
CAL	Cerebrovasa	lass of Sea	not resulting in t	ne underlying	ceuse given in		S AN AUTOPSY REORMED?	24b. WERE AUTO AVAILABLE	PRIOR TO
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Σ						_		1 TYES	2 NO
A N	25. WAS CASE REFERRED TO MEDICAL			20.01	ACE OF DEATH (Che				
딣	EXAMINER?	HOSPITAL: ER/Outpatie		THER:					
Ξĺ	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME O	F 28c. INJI	JRY AT	a U Other (Specify, 28d. DESCRIBE H		RED	
	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJUR	M 1 V	RK?			THE S	
BÁ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY —	At home, term, street	et, factory, office		281. LOCATION (S	reet and Number o	r Rural Route Number	¢.
	4 Homicide determined	building, etc. (Specify)				City or Town,	State)		
COMPLETED	29a, CERTIFIER Check only	AN: To the best of my knowled	ge, death occurred a	t the time, date	and place, and due	to the cause(a) and	menner se state	4	
		On the basis of examination as							er as stated.
	286. SIGNATURE AND TITLE OF CERTIFIES				29c. LICENSE NUM		-		
B	(Milly)	MD			D245	2119	DATE:	29 19 5	, rodr) »
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	I (ITEM 27) (Type, Pri	nt)	リッコ	71	1	×1117	
	William TAN.	MD 1645	Libert	4 Rd	Elde	esburg	MD	2178	+
	31. DATE FILED (1) (1) (1) (1) (1) (1) (1) (1)	32. REGISTRANTO SIGNATE		/	3,3,	7			
		Juna williams	A SATISFACTOR . W						



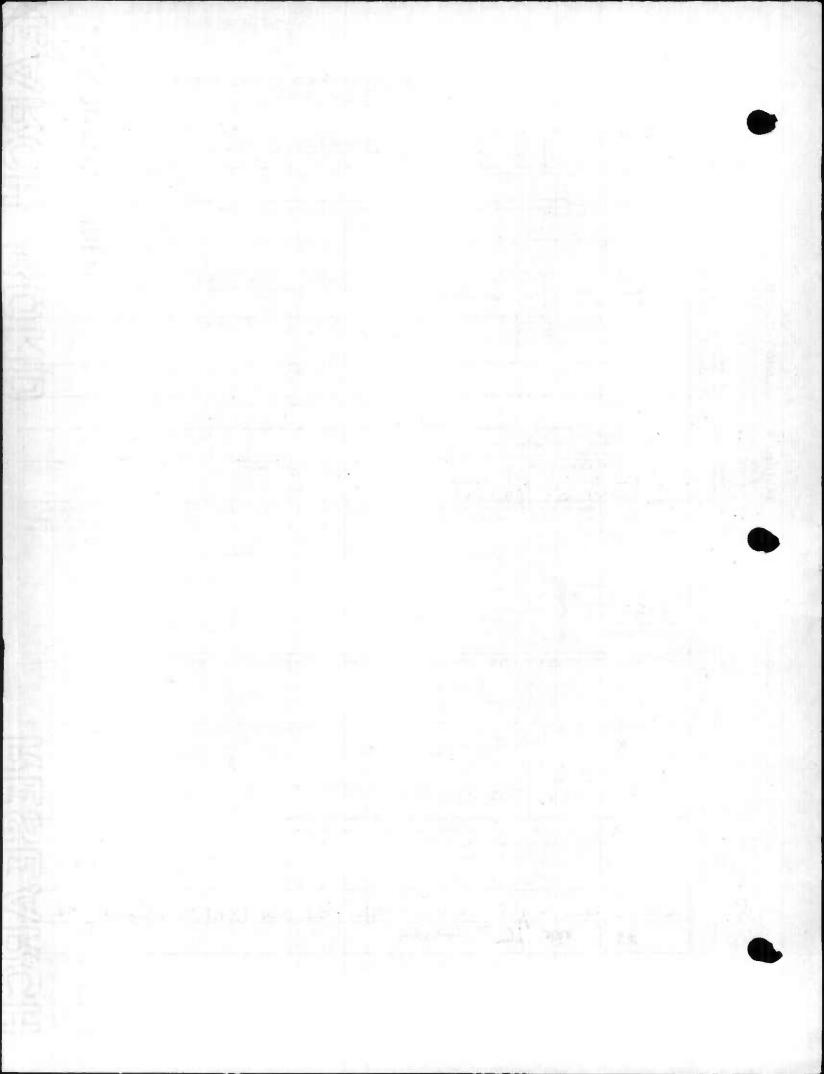
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been stoned by the attending obsistian and completely filled in by the funeral director name 5 should be de-
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		10 017710.	aby Box	10	ma c	Scott	5	20	95	3. TIME OF DEATH		
29		4. SOCIAL SECURITY NUMBER  NONE	UM 2 □ F	yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE C	Dey Holft) 95	8. BIRTHP Country)	- / //		
1, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give at UNI VASI AND RESIDENCE OF DECEDENT	reet and number) Held Cy5	1/m	111111111111111111111111111111111111111	TO MOVE			NTY OF DE			
permit. Pages	DIRECTOR		Himore	18c. CI1	Balh	ation of e	,		- 1	10d. INSIDE CITY LIMITS? 1 PYES 2 NO		
155	FUNERAL	1458 LOG INN ROAD			- 1	21401		1,00	SA	IAT COUNTRY?		
-UUZU ling physician. the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes,	ECENDENT OF HISPA specify Cuben, Mexic ES 2 NO Speci	en, Puerto R	? (Specify Yes or No— ican, etc.)	14. RACE Black, Specify	- American Indian, White stc.  Black		
hospital or attending lached for use as the ce.	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of ille. Do NOT u				KIND OF BUSINESS/IN	DUSTRY	750		
9 9 5		NONE.  17. FATHER'S NAME (First, Middle, Last)			NONE	16. MOTHER'S N	AME (First, M	NONE	1/			
retained by 5 should be notlifted at	O BE	ROMA SCOTT, SR.  190. INFORMANT'S NAME (Type/Print)		19b. MAILING	G ADDRESS (Stree	and Number or Rural	LANE.	or, City or Town, State, Zi	Kel (Code)			
be 5	۲	ROMA SCOTT, SR.		1458	LOG INN	RD. ANN	APOLIS	s, MD. 214	01			
rector,		20s. METHOO OF DISPOSITION  15 Suriel 2 Cremetion 3 Removal from State  20b. PLACE AND DATE Of DISPOSITION (Name of Campilery Cremetion of Campilery Cremetion of Campilery Cremetion of Campilery Cremetion of Campilery Cremetion of Campilery Campi										
death. Page 6 m		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  REESE & SONS MORTUARY, P.A.										
after of the moval.	$\vdash$	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest.  Approximate										
filled in on, or n		ahock, or heert fellure. Liet only one ceuse on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. Parsistant Fetal Cirarlatory  4 Lays										
B 5 - 5	z	DUE TO (OR AS A CONSEQUENCE OF):										
be se cian a cian a	CATIO	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A C	ONSEQUENCE O	F):							
th certificat ending phy I Hygiene p	ERTIF	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE O	F):							
2 4 5 5	AL C	PART II. Other eignificent conditions	contributing to deeth but	not reaulting	in the underlyi	ng ceuse given in	Part I.	24a. WAS AN AUTOPSY PERFORMED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO		
le law requires that that bas been signed by Dept. of Health and any 1 23 shows any 1	MEDICA						—	1 TES 2 NO		OMPLETION OF CAUSE OF DEATH?		
e faw req has been Dept. of	AN:	DID TOBACCO USE CONTR					N.D.					
SICIAN: The certificate h the State I, or item	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpetie		TH (Check only one OTHER: 4  Nursing Ho	ome 5 🗆 Rasidence	6 🗍 Other	(Specify)				
The this	ву рну	27. MANNER OF DEATH  1 Neturel 5 Pending Investigation	28e. OATE OF INJURY (Month, Day, Year)		M 1	IJURY AT /ORK? YES 2 NO	28d. DE\$0	CRIBE HOW INJURY OC	CURED			
OR ATTENDING DIRECTOR: After hours after death Item 28 Is ma	ED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, etc. (Specify)	At home, farm,	street, factory, off	Ice	28f. LOCA City of	TION (Street and Number Town, State)	r or Rural Ro	ute Number,		
祖 東京 =	OMPLE		CIAN: To the best of my knowled T: On the besis of szamination s									
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	U U	296 SIGNATURE AND TITUE OF CERTIFIER		7 11	ori, in my opinion,	29c. LICENSE NU				Hojith, Day, Year)		
TO THE De filed IMPOR	TO B	30. WAME AND ADDRESS OF PERSON-WHO	COMPLETED CAUSE OF DEATH	Tell	Print	P07	719	<b>&gt;</b> 5	120	195		
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		JUN 08 1995	32. REGISTRAR'S SIGNATI			,						



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	1. DECEDENT'S NAME (First, Middle Raymond	L. Swab				2. DATE	OF DEATH		EAR 75	3. TIME OF DEATH
	4. SOCIAL/SECURITY NUMBER  171-07-9483	XX M 2 □ F	AGE (In yrs. lest birthd	S. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	AUG	OF BIRTH h, Day, Year) 18 19(	06	Country	PA.
CTOR	90. FACILITY NAME (If not institution CUMBERLAND NU RESIDENCE OF DECEDE	RSING HOME			OR LOCATION OF D MBERLAND	EATH		ALLE(		
DIRE	PA.	BLAIR	10c.	DUNCANSV	ILLE					10d. INSIDE CITY LIMITS? 1 YES 2 NO
VERAL	10. STREET AND NUMBER 10 APPLE BLOSS	OM LANE			1. ZIP CODE			U.S		HAT COUNTRY?
BY FUN	11. MARITAL STATUS  1 Never Married 2 Marrie  XX Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 I IF YES, GIVE WAR	YES 2 NAO	It yes, sp	CENDENT OF HISPA Decify Cuben, Mexico S 2 NO Speci	en, Puerto		s or No 14		- American Indian, White, atc.
PLETED		"S EDUCATION st grade completed)  Cotlege (1-4 or 5+)	(Give kind life. Do NO	IT'S USUAL OCCUPATE of work done during mo of use retired.)	ost of working			SINESS/INDUS		OR
BE COMPL	17. FATHER'S NAME (First, Middle, L SHEEDER SWAB				16. MOTHER'S NA MYRTLE	AME (First,	Middle, Malden			
TO	196. INFORMANT'S NAME (Type/Prii RAYMO'ND SWAB	nt)		.BOX# 442					ode)	
	23. PART I. Enter the disease shock, or heart for	es, or complications that ca silure. List only one cause	used the death. Con each line.		DECATUR S					Approximate
rion	iMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions,	a. Carama DUE TO (OR	on each line.	Prostate E OF):	ode of dyling, suc	STREE				Approximate interval Betwood Donset and D
ERTIFICATION	iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Carama DUE TO (OR  b. DUE TO (OR	on each line.  OMA OF AS A CONSEQUENCE	Prostate Frostate E OF):	ode of dyling, suc	STREE				Approximata interval Betw Onset and D
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BY PHYSICIAN: MEDICAL	Snock, or heart to iMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST  PART II. Other algnificant context in the condition of	a. Can Composition of the best of my XAMINER: On the best of my XAMINER: On the best of sami	AS A CONSEQUENC  AS A C	Do not enter the money of the m	pade of dying, such a control of the	Part I.  Part I.  6 Other  28d. DE:  28t. LOC	24e. WAS AN PERFOI 1 VES 2  ATION (Street or Town, State)  use(e) and main and place, and	AUTOPSY RMED?  INJURY OCCUR and Number or	24b.  24b.  Rural A	WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?  1 YES 2 NO



YEAR

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

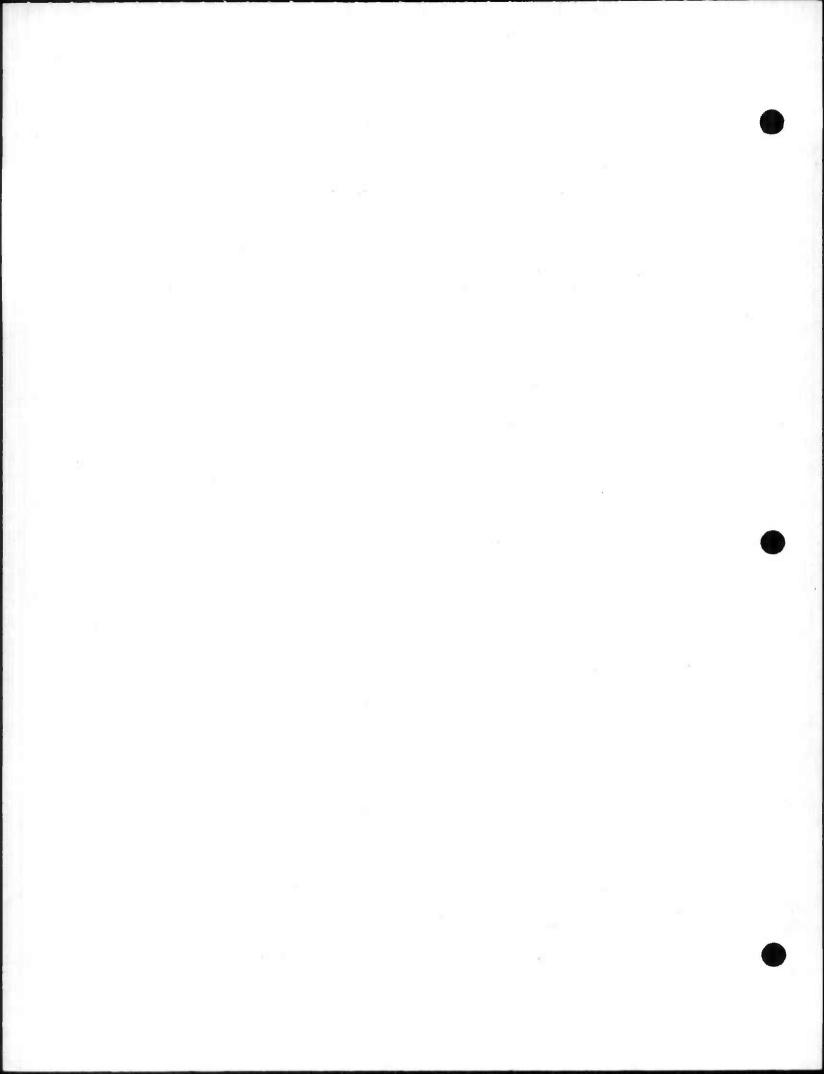
REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) LUCILE FLEMING TWOGOOD 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 1 M 2 F 521-18-8146 79 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, DIRECTOR WESTWOOD RETIREMENT HOME BETHESDA RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY BETHESDA FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE use as the burial-transit 5101 RIDGEFIELD ROAD 20816 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES. BALTIMORE, MARYLAND 21215-0020 Never Married 2 Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (So (Give kind of work done life. Do NOT use retired.) n and completely filled in by the funeral director, page 5 should be detached for to burial, cremation, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) OFFICER once. 17. FATHER'S NAME (First, Middle, Lest) 76 LEON SCOTT TWOGOOD BE notified 19a. INFORMANT'S NAME (Type/Print) 2 AUGUSTUS P. CRENSHAW, III Page 6 may be Pe 26a. METHOD OF DISPOSITION
1 X Burtal 2 □ Ofernation 3 □
4 □ Donation 9 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must PROVO CITY CEMETERY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE death. hours after medicai shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finsi disesse or condition the executed within 24 BRONCHOGENIC CARCINOMA event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate the attending physician 1 Mental Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 0 MEDICAL signed by the BUY OBSTRUCTIVE PULMONARY DISEASE Shows been : PHYSICIAN: . OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item HOSPITAL 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 5 Pending BY 2 Accident 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Soecily) .00 3 Suicide COMPLETED # Could not ba 28 4 Homicide detarmined Hem HOSPITAL FUNERAL I within 72 I = TO THE HOSPITA
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IMPORTANT: II

FOR

VAN 1995 7:11 P.M IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig AUG. 16, PENNSYLVANIA 1915 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MONTGOMERY 10d. INSIDE CITY 1 YES 24 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT 18. MOTHER'S NAME (First, Middle, Maiden Sumame) TESSIE FLEMING 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 WINNETT RD. CHEVY CHASE, MD. 20815 20c. LOCATION -- City or Town, Stata DATE 5/30 PROVO, UTAH JOSEPH GAWLER'S SONS, INC 20016 5130 WISCONSIN AVE. N.W. WASHINGTON, D.C. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or reapiratory strest, Approximats Onset and Death 3 MONTHS PART II. Other significent conditions contributing to daeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO DE DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN OTHER:
4 🖸 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28t, LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attended. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DI3771 MAY 26, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED QUISE OF DEATH (ITEM 27) (Type, Print) DAVID LUTHRINGER, M.D. 5530 WISCONSIN AVE # 1240 CHEVY CHASE, MD. 20815 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Davidson Revolate MAY 31 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		
1	1. DECEDENT'S NAME (First, Middle, Last)			4		2. DATE OF DEATH		3. TIME OF DEATH
	Maurice	Gano	Tu	cker		MAY 2	9.1993	1020A
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. leaf birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. Bi	RTHPLACE (State or Foreign
4	459-38-5521	1 💢 M 2 🗆 F 7	5 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Sept. 13,		klahoma
	9a. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY O	
DIRECTOR	Shady Grove Adve	ntist Hospit	al	Rock	ville		Monto	OMOXII
5	RESIDENCE OF DECEDENT							
뷘	10a. STATE 10b. COUNT	Y	10c, CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
		tgomery		Rockvil1	le			1 🖾 YES 2 🗌 NO
FUNERAL	10e. STREET AND NUMBER			10	of, ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
<u> </u>	500 West Montgo	mery Avenue			20850		Unite	d States
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 X YES	N U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	or No- 14. R	ACE — American Indian, Back, White, etc.
	1 🔀 Never Married 2 🗌 Married 3 🗍 Widowed 4 🗍 Divorced	IF YES, GIVE WAR OR D	MIES		S 2 X NO Specifi			pacity:
		World War						White
	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of	Work done during m	ION ost of working	16b. KIND OF BUS	SINESS/INDUSTR	Y
ا ۲	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us					
COMPLET		4	None			Not A	pplicab	le
3	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
╏	Fred E. Tucker					Gano		
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Code,	)
	Gordon Gano Tucke					, Dallas,	Texas	75225
	20a, METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Rem	oval from State	D. PLACE AND DATE	OF DISPOSITION	ay 31, 19	995DATE 20c. LO	CATION - City o	r Town, State
	4 Donation 5 Other (Specify)	S	parkman-1	lillcres	t Memoria	1 Park Dal	las, Te	xas
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE AA	M0083					
- 1	Darbarasom	Muldenga	whence	Bethe	esda-Chev	y Chase, I	nc. 755	ne/ 57 Wisconsi: 314-3501
	23. PART I. Enter the diseases, or o	complications that cause	d the death Do	Aveilt	de, betne	sua, Maryi	and 200	
	shock, or heert failure.	List only one ceuse on e	each line.	OL STURE LING INC	ode of dying, suc	n as cardiac or respi	ratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	ASPIRA		Picua	1			Onset and Di
	resulting in death)				MIMON			2 day
		SEPTIC	A CONSEQUENCE OF	F):				2
5	Sequentially list conditions,		A CONSEQUENCE OF					of day
<b>E</b>	If sny, leading to immediate cause, Enter UNDERLYING	DOE TO (OR AS )	A CONSECUENCE O	r):				Í
3	CAUSE (Disesse or Injury that initiated events	c. DUE TO (OR AS /	A CONSEQUENCE OF	F)·				
	resulting in death) LAST							
CERTIFICATION		d						
DICAL	PART ii. Other significent condition	s contributing to death b	out not resulting	In the underlyin	g cause given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDI
3						1   YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUS
MEC							M NO	OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH VE	SINO	UNCERTAIN	V IV		I I IES Z [M] NO
4	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT			· E		···
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:		10 M		
	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. T/M		ne 5 Residence		N HIRV OCCUPA	
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	ORK? YES 2 NO	28d. DESCRIBE HOW II	NUMT UCCURED	,
ā	2 Accident Investigation	28s. PLACE OF INJURY	( — At home fa-			201 1 00171011 101	and Museum	-10-41
3	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spe	cify)	most, rectory, orne	-	281. LOCATION (Street a City or Town, State)	ing Number of Rui	wirioute Number,
	190. CERTIFIER							
O P	(Check only	CIAN: To the best of my know						
5	2 MEDICAL EXAMINE	R: On the besis of examination	n end/or investigatio	n, in my opinion, o	death occured at the	time, date and place, an	d due to the caus	e(a) and menner as state
	196. SIGNATURE AND LITLE OF CERTIFIER	1			29c. LICENSE NUM		29d. DATE SIGN	NED (Month, Day, Year)
	2 DE.	2114			D100	cad	<b>MAY</b>	1 29, 1995
2   -3	O. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE					- 1	300
	EDGARH.	LEVIN	, 980	3-5) 10	अर व रवर	AJF <	SILVER	SPRIME
3	11. DATE FILED (Month, Day, Year)	32. REOISTRAR'S SIGN				1	211-1-1	-1
	JUN 01 1995	Julia Daviden	P. 1 10			,		,
		THE WHOME	Woodell					



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-	OR ATTENDING PHYSICIAN:
DIVISION OF	
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	-

3 Suicide

4 Homicide

29b. SIGNATURE AND TITLE OF CERTIFIER

COMPLETED

BE

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. False to may be retained by une invagined by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

									95	5 1	8695
	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND /	DEPAR ERTIF	TMENT (	F HEALTH A	ND MEN	ITAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	NED	7	AN	NAS	SEE		NAV 2	8 1	YEAR 3	5. OF P M
	4. SOCIAL SECURITY NUMBER 217-08-6075	1 🖾 M 2 🗌 F	SE (In yrs. las	t birthday) YRS.		YS HOURS I	MIN. (I	ATE OF BIRTH Month, Day, Year) ept. 2,	1943	Country)	ACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give s Shady Grove Adve		tal		·	9b. CITY, TOWN OR LOCATION OF DEATN  ROCKVille  Monto					
DIRECTOR	10e. STATE 10b. COUNTY Maryland Mon	tgomery		1000	y, town on L Rockvi						0d. INSIDE CITY LIMITS?  X YES 2 NO
FUNERAL	100. STREET AND NUMBER 304 Monroe Stre	et, #1				10f. ZIP CODE 20850	)			ZEN OF WH	AT COUNTRY?
B≺	11. MARITAL STATUS 1 Never Married 2 🔀 Married 3 Newed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YI IF YES, OIVE WAR OF	ES 2X N		If yo	DECENDENT OF H B, specify Cuban, B YES 2 X NO	Mexican, Pue	RIGIN? (Specify Yes erto Rican, etc.)		14. RACE Black, 1 Specify:	- American todien, White, atc.
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	(G/	CEDENT'S ve kind of w Do NOT us NOI	e retired.)	PATION g most of working		166. KIND OF BUS		USTRY	
BE CON											
TO B	19e. INFORMANT'S NAME (Type/Print)  Leila E. Tennas:	see	196	MAILING	ADDRESS (St		Rural Route I	Number, City or Town	n, Stete, Zip	Code)	nd 20853
	20s. METNOD OF DISPOSITION 1	oval from State	20b, PLACE A	ND DATE O	OF DISPOSITIO		1 9 9	DATE 20c. LOC	CATION —	City or Town	
	21. SIONATURE OF FUNERAL SERVICE LIC	Leuton -	M(	00202	Robe Inc.	e and address of A. Pu	of FACILITY IMPHIE	y Funer	al Ho	ome/ I	Rockville
	23. PART I. Enter the diseases, dreshock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)	complications that cau- List only one ceuse or a. ACUTE DUE TO (OR A	esch ilne.	YOC	ARDIA	mode of dying.	, such ss	cardiec or respin	ratory sm	est,	Approximata Interval Between Onset and Daath
CERTIFICATION	Sequentisliy list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A									
PHYSICIAN: MEDICAL C	PART II. Other significant condition		but not re	esulting in	n the under	ying cause give	on in Part i	24a. WAS AN A PERFORE	MED?	CO	ERE AUTOPSY FINDINGS INLABLE PRIOR TO DIMPLETION OF CAUSE F DEATH?  YES 2X NO
IAN:	DID TOBACCO USE CONTE	RIBUTE TO CAUSE			S NO		TAIN I				
IYSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	utpatient 3	□ DOA	OTHER: 4 Nursing	Home 5 - Reside	7				
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJUR (Month, Day, Yes		26b. TIME	JRY	WORK?		DESCRIBE HOW IN	JURY OCC	URED	

26f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)

29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated one).

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

2 MEDICAL EXAMINER: On the besis of examination and/or	investigation, in my opinion, death occured at the time, data and place,	and due to the cause(s) and manner as stated

		nen	ow	MO		
D.	NAME AND	ADDRESS OF PERSON	WNO COMPLETED	CAUSE OF DEATH //	TEM 27) (7/04	9

datermined

0-33224 Tav #401 Rockville

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) MAY 29, 1995

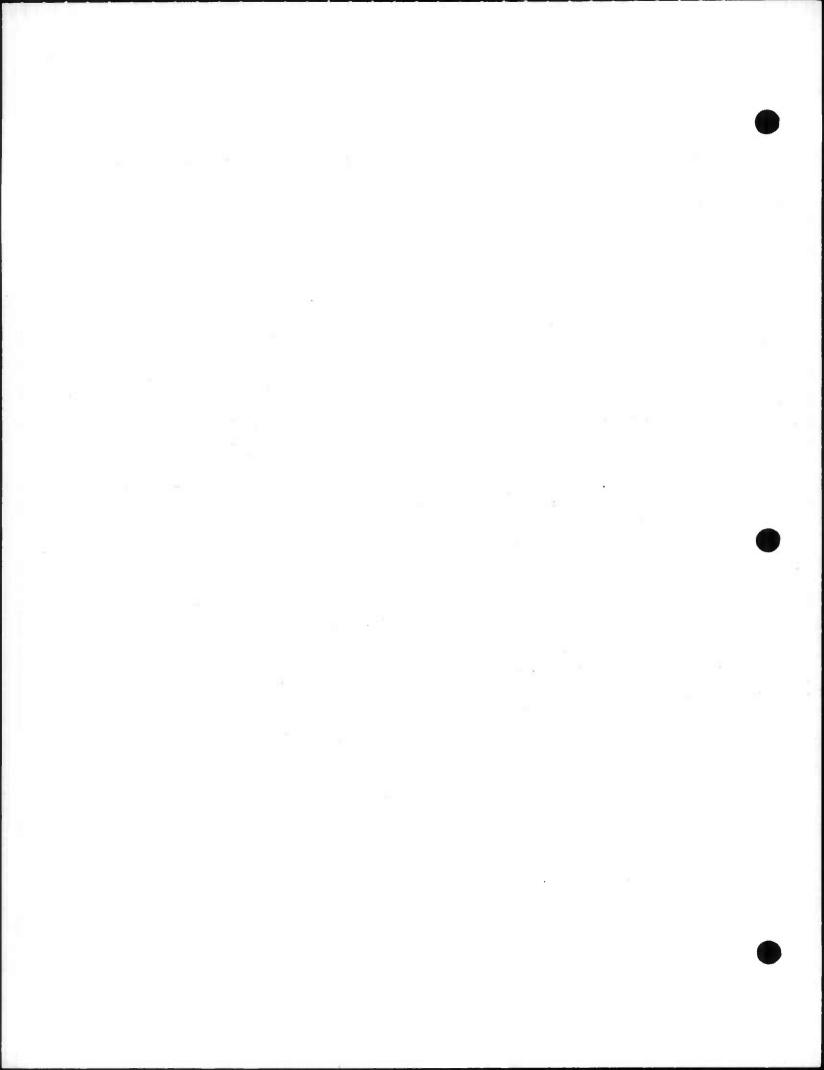
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50W Edmonston

32. REGISTRAR'S SIGNATURE

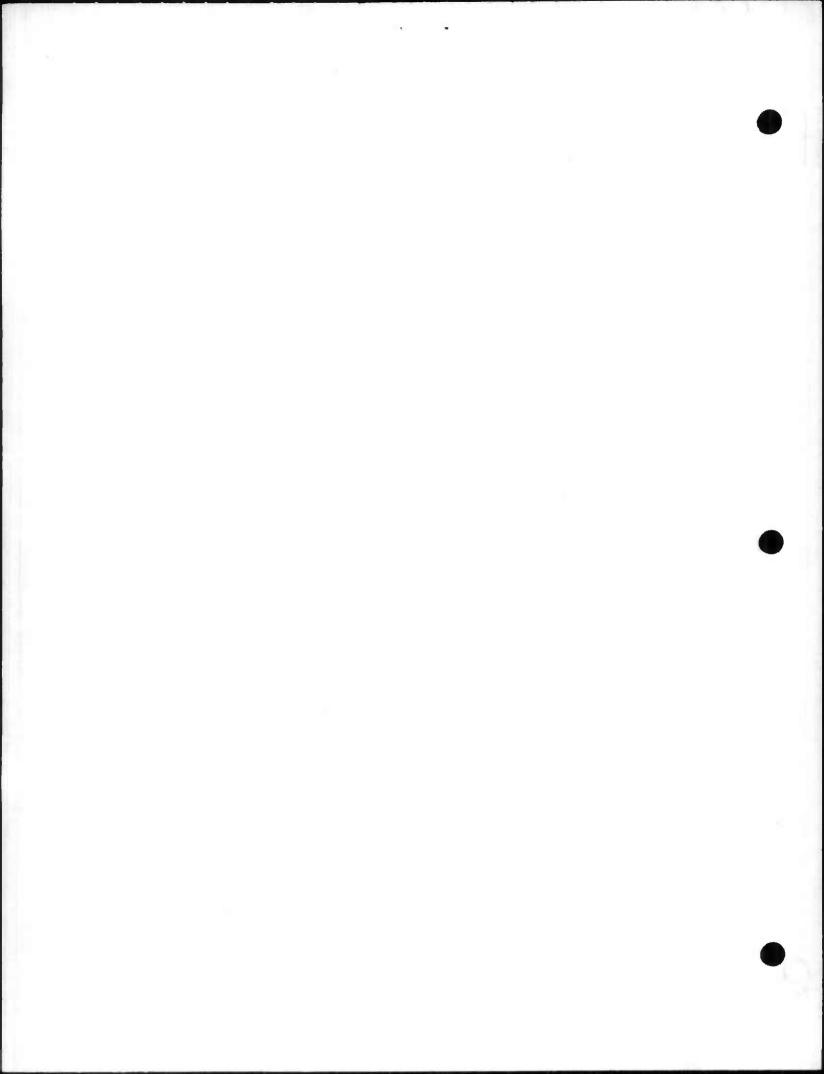
31. DATE FILED (Month, Day, Year) JUN 01 1995



	,	Amended#10	E # 100	et 20	L TE	1 1/2	h 0	Jom.	19090	
		FOR 1 - STATE REGISTRAR	STATE OF MARYL	ANU / UEPAR	KIMENI UF	HEALIH AND	MENTAL HYGIEN	T MO	nigomry	
		REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE O	F DEATH	REG. NO		Counti	
		Davin TA	VIDE				2. DATE OF DEATH MONTH DEATH MAY 28	AY 1995	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign	
Pin		243-07-4097	120 M 2 □ F 8	28/ YRS.	MONTHS DAYS		Dec.19,	1913 Di		
3 should	Œ	90. FACILITY NAME (If not institution, give str Holy Cross Ho				er Spri		Montgo		
1. 2,	CTO	RESIDENCE OF DECEDENT					1197 1115	Honege	omer y	
physician. burial-transit permit. Pages 1,	L DIRECTOR	10a. STATE 10b. COUNTY			D.C.	.c. Washington			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
m. ransit pen	FUNERAL	2515-13th St. N.W. #54				20009	J	10g. CITIZEN OF WHAT COUNTRY? USA		
the file	Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Olivorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 - NO	13. WAS D	ecendent of Hispa specify Cuben, Mexic ES 2 1 NO Speci	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) fy:		E — American Indian, ok, White, etc.	
	TED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S (Give kind of	work done during i	TION most of working	16b. KIND OF BU	SINESS/INDUSTRY		
hospital or ached for u	COMPLET	Elementary/Secondary (0-12) 9th	College (1-4 or 5+)	Ille. Do NOT u	tenanc			rnment		
the hospit detached once.	NO.	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden			
× 2 %	BE C	Edward Taylor				Annie	Walker			
5 should notified	2	19a. INFORMANT'S NAME (Type/Print) Edith L. Tayle	- M			t and Number or Rural	Route Number, City or Tow			
page a		20a, METHOD OF DISPOSITION 1-N Burlel 2 Cremetion 3 Remo	206	PLACE AND DATE	OF DISCOSITION	St. N.I		D.C. 2	own, Stata	
		4 Donation 8 Other (Specify)	1		PT-II	corc wer	$n \neq 6/1/95$	Suit1a	and, MD.	
60 = 60		22. NAME AND ADDRESS OF FACILITY 600 Kennedy St. NW. Washington, D.C. 20011								
filled in by on, or remo		23. PART I. Enter the diseases, or co shock, or heert fellure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Aspira	leo.	mot enter the m	node of dying, auc	ch aa cerdlec or reep	iratory arrest,	Approximate interval Between Onset and Death	
ath certificate be executed trending physician and contain Hygiene prior to buria, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  LINE TO (OR AS A CONSEQUENCE OF):  LINE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.								
SICIAN: The law requires that the de certificate has been signed by the a the State Dept. of Health and Menv i, or Item 23 shows any Injury.	MEDICAL	PART II. Other significent conditions  Di Lettes	contributing to death be	ut not resulting	in the underlyi	ing cause given in	Part I. 24a. WAS AN PERFOF	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
has been Dept. of 23 sho	N.	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	F DEATH YE	ES   NO	UNCERTAI	N E		1 YES 2 NO	
N: The Is ficate has State De Item 2	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only on	e)				
certific the S	HYS	1   YES   2   NO	1 Inpatient 2 ER/Outpi		tient 3 DOA 4 Nursing Home 8 Residence 8			8 Other (Specify)  28d, DE\$CRIBE HOW INJURY OCCURED		
this with	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		JURY V	YORK?	280. DESCRIBE NOW I	NJORY OCCURED		
TTENDI CTOR: A after di 28 Is		3 Suicide & Could not be datarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, ferm, :	street, factory, off	fica	281. LOCATION (Street 1 City or Town, State)	and Number or Rural i	Route Number,	
OR A DIREC hours	7	29a. CERTIFIER	IAN: To the best of my knowle	edge, death occurr	ed at the time, de	its and place, and due	to the cause(s) and mar	nner as stated,		
P D D	0.	(Check only								
Z 3 2 =	SOMP		On the besis of examination	and/or investigation	on, in my opinion,	, death occured at the	time, data and placa, an	a doe to the causele	i) and manner as stated.	
THE HOSPITAL THE FUNERAL Iled within 72 I	BE COMPLETED			and/or Investigation	on, in my opinion,	29c. LICENSE NUI		29d. DATE SIGNED	- WIN-Y	
TO THE FUNERAL DI TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite	TO BE COMP	One) 2 MEDICAL EXAMINER  29b. SIONATURE AND TITLE OF CERTIFIER	On the besis of examination	2					- WIN-Y	
THE HOSPITAL THE FUNERAL Iled within 72 I	BE	2 MEDICAL EXAMINER	On the besis of examination	ATH (ITEM 27) (Type)	, Print)	29c. LICENSE NUI		29d. DATE SIGNED	29, 1955	

5661 62

		FOR STATE REGISTRAR	STATE OF M	IARYLA	ND / DEPAR	RTMENT OF I	HEALTH AND		GIENE a. no.		
		1. DECEDENT'S NAME (First, Middle, Lest)  BABY GIRL				THE	SSEN	2. DATE OF DE. MONTH JUNE 6	DAY	YEAR	3. TIME OF DEATH 3:12A M
D		4. SOCIAL SECURITY NUMBER N/A	5. SEX 1 M 2 X F	6. AGE (In	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN,	7. DATE OF BIR (Month, Day, May 30,	ΓH 6ar)	Count	IPLACE (State or Foreign
pinous	~	Se. FACILITY NAME (If not Institution, give str	eet end number)			9b. CITY, TOWN	OR LOCATION OF D			INTY OF D	4
1, 2, 3	ECTOR	THE JOHNS HOP RESIDENCE OF DECEMENT 10s. STATE 10s. COUNTY	KINS HOS	PITA		-	IMORE CI	TY			
permit. Pages	DIR	Maryland Prince	George			y, town on loca urel	TION				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
150	FUNERAL	100. STREET AND NUMBER 804 Kay Court #31	.4				1. ZIP CODE		10g. CIT		VHAT COUNTRY?
21215-0020  If or attending physician, for use as the burial-transit	BY	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 { IF YES, GIVE WA	YES	2 X NO	13. WAS DEG	CENDENT OF HISPAL lecify Cuben, Mexica 2 X NO Specif	an, Puerto Rican, a	ity Yes or No-	14. RACE Black Speci	E — American Indian, k, White, atc.
2 2 2	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed)  College (1-4 or 5+)		Give kind of life. Do NOT u	USUAL OCCUPATI work done during mose retired.)	ON ost of working	16b. KIND (	OF BUSINESS/IN		WIII GC
	COMPL	N/A			N/A			N/A			
YLAN by the hos be detach at once.		17. FATHER'S NAME (First, Middle, Lest)						AME (First, Middle, I			
	8	James Everett  19a. INFORMANT'S NAME (Type/Print)			105 MAII INC	ADDRESS (Comme	Brenda	Theisse			
be retained ge 5 should e notified	2	Brenda Theissen					#314, L				707
AORE, le 6 may be rector, page must be		20g_METHOD OF DISPOSITION 1  Buriel 2  Cremation 3  Remove 4  Donation 5  Other (Specify)	val from State	20b. P	LACE AND DATE	of disposition (Na ther place) Cemeter	ame of	DATE 2	Laurel,	City or To	wn, State
BALTIMORE, after death. Page 6 may be word. cal examiner must be		21. SIGNATURE GO FINERAL SERVICE LICE	01	1		313 T	dson Fun	eral Hor	ne, P.A	rylar	
P.O. BOX 68760  h certificate be executed within 24 hours anding physician and completely filled in I Hygiene prior to burial, cremation, or re or other traumatic event, the med	SERTIFICATION	23. PART I. Enter the disease of combook, or heart afters. L.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	-ELE CI	FOV OR AS A CO	h line.	enical				reat,	Approximate Interval Between Onset and Death 6/6/95
uires that the signed by the Health and Miss any Inja	MEDICAL C	PART ii. Other algnificent conditions	contributing to d	deeth but	not resulting	in the underlyin	g ceuse given in	PI	AS AN AUTOPSY ERFORMED?	24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ا بر الله حد		DID TOBACCO USE CONTR	BUTE TO CAU	JSE OF	DEATH YE	S NO NO	UNCERTAIL	N D			TES ZANO
를 많을 를	PHYSICIAN:		HOSPITAL:			H (Check only one)					
SICIAN: The Certificate the State	HYS	1 TYES 2 NO	1 Inpatient 2 I		ent 3 DOA	4 - Nursing Hom	e 5 Residence				
NG PHYS fer this cath with	BY P	Natural 5 Pending Investigation	(Month, Day			URY WO	RK7	28d. DESCRIBE I	TOW INJURY OC	CURED	
TTENDI TTENDI TOR: A after de	COMPLETED B	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	INJURY — tc. (Specify)	At home, ferm, s	dreet, fectory, offic		281. LOCATION (S City or Town,	Street end Number Stete)	or Rural R	oute Number,
AL OR A L DIREC 2 hours	7	290. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of m	ny knowled	ge, death occurre	ed at the fime, date	and place, and due	to the cause(e) an	d menner ee stat	ed.	
TO THE HOSPITAL OF TO THE FUNERAL DE TIEN WITHIN 72 he IMPORTANT: IT IN	Š.	one) 2 MEDICAL EXAMINER:									and menner se stated.
THE HE FL	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	VX	_			29c, LICENSE NUM	1 - 1 - 1	29d. DAT	E SIGNED	(Month, Day, Year)
2 6 8 ₹	2	20 NAME AND ADDRESS OF DEPOSIT WAY	11	H80			980 16/6/92			192	
		DR. JAMES FEHR 600					, MARYLAN	ND 21287			
		31. DATE FILED (Month, Day, Year)	32, REGISTRAR	'S SIGNATE	JRE						
2 L		JUN 0 8 1995	Jalia Daw	clear A	Cardall						

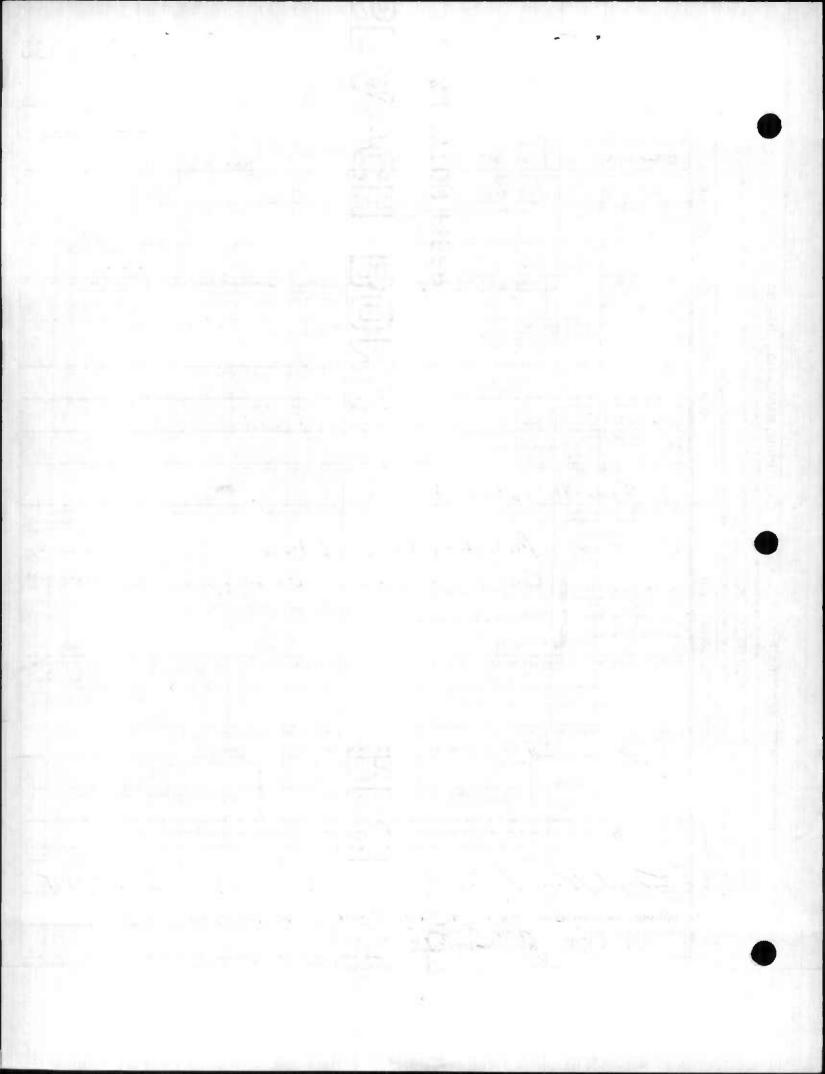


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DIVISION OF VITAL RECORDS, P.O. BOX 68760.  BALTIMORE, MARYLAND 21215-0020
TO THE FUSH INL. OF AT LENDING FITSOLICIAN, THE WAY REQUIRED that the defined to the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examinar must be notified at ance.

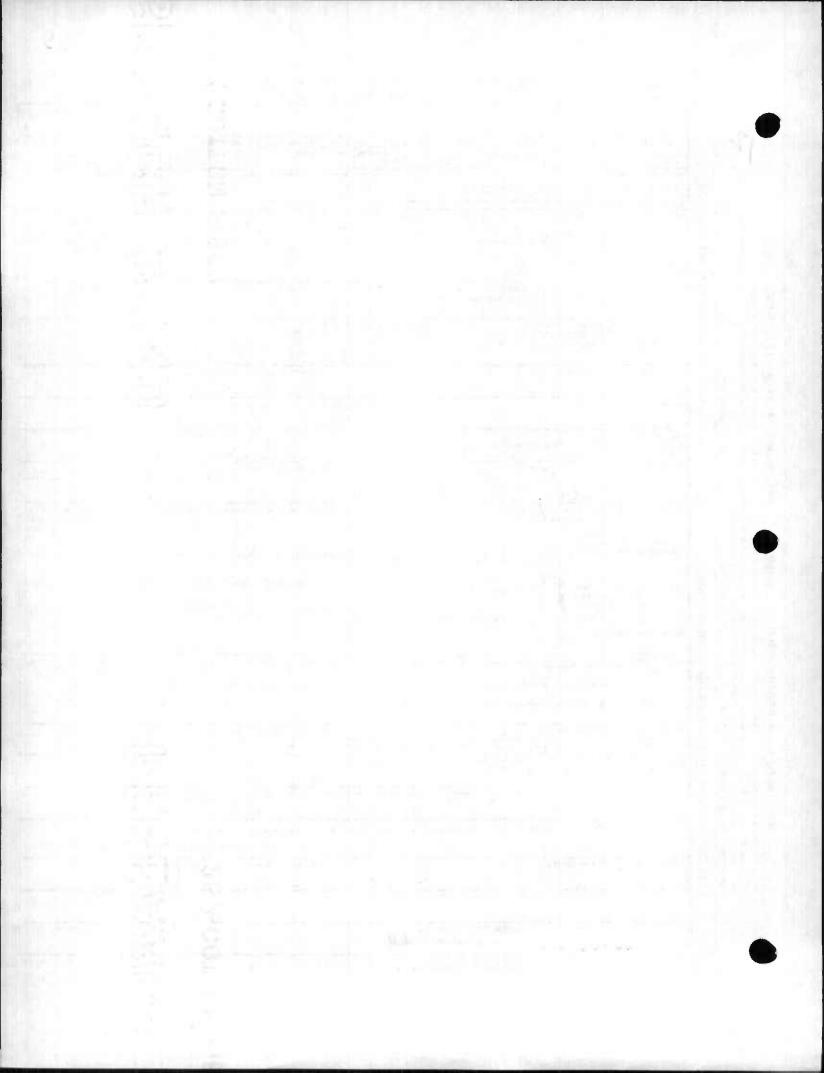
	1 - STATE REGISTRAR	STATE OF MARY		MENT OF H			GIENE S. NO.			
		LLA MAE THO			2. DATE OF DEA	03	3. TIME OF DEATH			
	4. SOCIAL SECURITY HUMBER 215-03-0202	1 🗆 M 2 🔀 F	78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT	bar)	Country	vLACE (State or Foreign yland	
FOR	90. FACILITY NAME (II not institution, g  Dorchester Ge	mbridge								
DIRECTOR	Maryland Dorchester				тоwn оя Location Cambridge				10d. INSIDE CITY LIMITS? 1 KNyes 2 \( \text{N} \) NO	
FUNERAL I	10. STREET AND NUMBER 403 Oakle		ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY?					
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF	S 2 X HO	If yes, spi		INIC ORIGIN? (Spec an, Puerto Rican, e	Ify Yes or Ho-	14. RACE Bleck,	- American Indian, White, etc.	
COMPLETED	15. DECEDENT'S (Specify only highest of Elementery/Secondary (0-12) 1.2	College (1-4 or 5+)	16a. DECEDENT'S ( (Give kind of we kind. Do NOT use Sewing I	ork done during mo: retired.)	of working			manufacturing		
BE	17. FATHER'S HAME (First, Middle, Lest Fr  190. IHFORMANT'S HAME (Type/Print)	ank Lewis	19h MAH ING	ADDRESS (Street o		Blanch Route Number, City	e Mur	phy		
10	Mrs. Patricia A		424 Le	Compte	St. Cam	bridge M	D 2161	3		
	20b. PLACE AND DATE of DISPOSITION (Name of Competents) 3 Removal from State 2 Commetton 3 Removal from State 2 Donation 6 Other (Specify) DOTCHESTET NETWORK OF Cambridge No. 121. SIGNATURE OF FUNERAL SERVICE LICENSEE									
	Thomas Funeral Home 700 Locust St., Cambridge MD 21613									
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory strest, shock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence of):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								Lhkhoun	
MEDICAL	PART II. Other significant condi	tions contributing to desti	but not resulting in	PERFORMED?  1 TYES 2 SHO  OF E					WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:									
	1 VES 2 VAHO 1 Inpettent 2 ER/Outpettent 3 DOA 4 Hursing Home 5 Residence 6 Other (Specify)  27. MANNER OF DEATH 1 Hetural 5 Pending 28a. DATE OF INJURY (Morth, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 NJURY AT VORK? 1 VALUE OF INJURY OCCUREO									
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 25s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  25s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)  28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLETED	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.  MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.									
TO BE	299. SIGNATURE AND TITLE OF CERT	has fight	DEATH (ITEM 27) (Type	Print)	D-28	209	29d. Da	Line	Month, Day, Year) 5, 1895	
	Edmund Maclaughlin, M.D. 4 Aurora Street Cambridge, MD 21613									
	JUN 0 6 1995	Jelin Dawidson	Revolath							





BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	se medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF N		DEPARTM			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest)		0111155115			E9188.5	2. DATE OF DEATH MONTH D		3. TIME OF DEATH
	DOROTHY L  4. SOCIAL SECURITY NUMBER	EE T	OUNSENI 6. AGE (In yrs. lest		NOER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1995	9:50 A M HPLACE (State or Foreign
	224-LB-9359  96. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 F	46	YRS. MON	THE DAYS	HOURS MIN.	MAR - 247	1949 VI	RGINIA
TOR	FALLSTON GENER		ITAL		ALLST	ON	EATH	HARFOR	
DIRECTOR	10a. STATE 10b. COUNT				WN OR LOCAT				10d. INSIDE CITY LIMITS?
IL DI	MARYLAND HAR	FORD		E I	GEWOO	ZIP CODE		10g, CITIZEN OF	1X YES 2 □ NO
FUNERAL	JPJG-H VZHBA Z	QUARE				21040		U-Z-	
B∀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 X N		If yes, spe		NIC ORIGIN? (Specify Year, Puerto Rican, etc.) y:	Spec	E — American Indian, ik, Whita, etc. iiiy: LACK
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	e completed)	(Gi	CEDENT'S USU, ve kind of work of Do NOT use reti	tone during mos	N t of working	16b. KIND OF BU	SINESS/INDUSTRY	
MPLE	Elementary/Secondary (0-12)	College (1-4 or 5 +	)		COLLE	CTOR	STATE	GOVERN	MENT
00	17. FATHER'S NAME (First, Middle, Last)  ALEXANDER WEE	DEN	plat.				E COLEMA		
TO BE	19a. INFORMANT'S NAME (Type/Print)	JEN .	196	. MAILING ADD	RESS (Street as		Route Number, City or Tox		
F	CONNIE HARRIS						R EDGEW		
	1 Donation 8 Other (Specify)	novel from State	Cometery, cres	IND DATE OF DE	N BAP	TIST C	DATE 200. LO	JALKERT	
1	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE BE	el		HOME	D ADDRESS OF FA		TIDEWAT	ER FUNERAL
CERTIFICATION	23. PART i. Enter the diseases, or abock, or heart feiture IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. Due to Due to C. Ch	coused the dese on each line.	PUENCE OF):  ALCO		lic Li			Approximata Interval Between Onset and Dauth  3 Days  25 years  25 years
AL M	PART II. Other algorificant condition Respiratory Severe Meta	- 1				cause given in		RMED?	D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OT	26. PL	ACE OF DEATH (Ch	neck only one)		
BY PHYSICIAN: MEDIC	1 VES 2 NO  27. MANNER OF OEATH  Netural 5 Pending  2 Accident Investigation	1 Inpetient 2 28a. DATE OF (Month, De	INJURY ay, Year)	28b. TIME OF INJURY	Nursing Home 28c. INJI WO 1 Y	JRY AT	6 Other (Specify) 28d. DESCRIBE HOW		
TED	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At horetc. (Specify)	me, term, street	, tactory, office		261. LOCATION (Street City or Yown, State		Route Number,
COMPLETED	one)						to the cause(s) and ma		s) and manner as stated.
TO BE C	296 SIGNATURE AND TITLE OF CERTIFIE	a Za	merca	mp		29c. LICENSE NUI	WBER 0819	≥ May	10,1995
-	30. NAME AND ADDRESS OF PERSON W  MARCO A ZAM  31. DATE FILED (Month, Dey, Year)	DPA MD	C /O	Fallso	bon Ge	neval H	uspital 8	Ellston,	Maryland
	JUN 0 5 199	5 . 1	ander Ro	rdall				Sept.	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

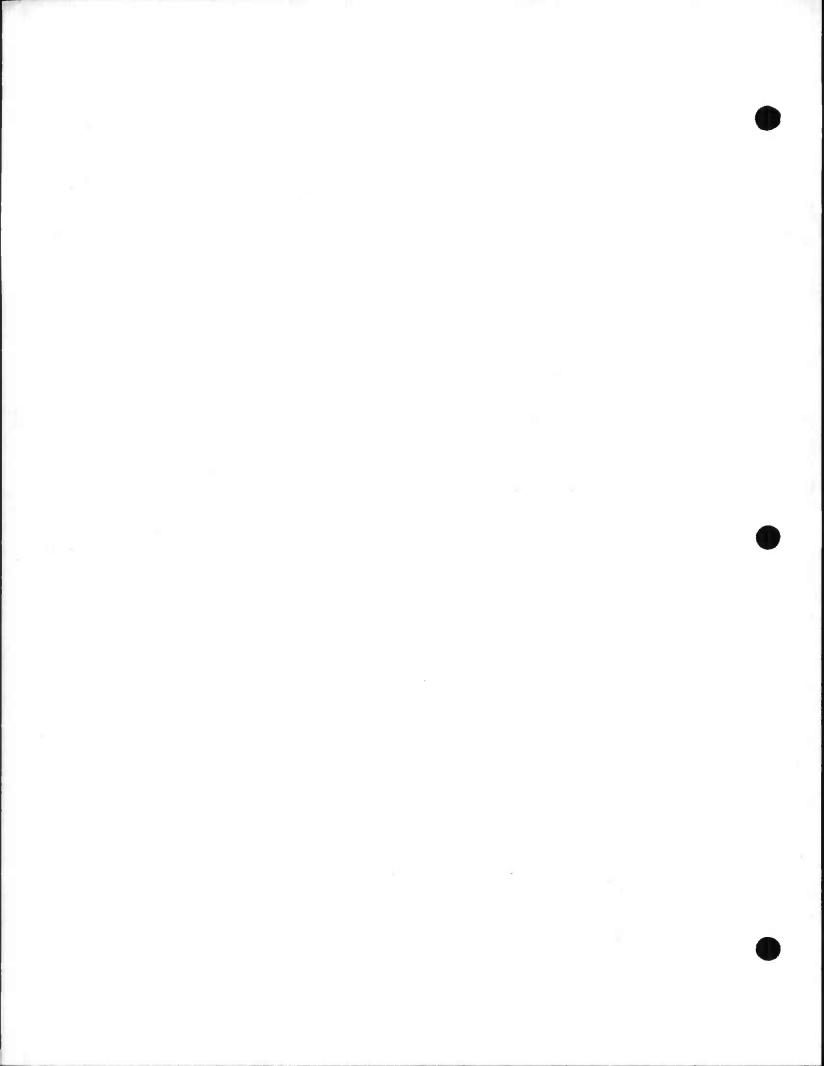
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

STATE	OF.	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IENI
		C	ERTIFICATE	0	F DEAT	THE		DEG	NO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAI CERTIF	RTMENT	OF H	IEALTH DEAT	AND I	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE C	OF DEATH			3. TIME OF DEATH
	VERNON LEE	E TERRY						June	3,	1995	YEAR	8:00 AM M
	Control of the contro		rs. last birthday)	IF UNDER	1 YEAR	# UNDER	50001	7. DATE C	Day, Year)		8. BIRTH	IPLACE (State or Foreign
	404 00 DIGI	R M <sup>2</sup> □ F 69	YRS.	WONTHS	DAYS	HOURS	MINI.	March	1 29,	1926	Wes	t Virginia
~	6a. FACILITY NAME (If not institution, give atreet	and number)		96. CITY	, TOWN (	R LOCATIO	ON OF DE	EATH		9c. COUR		
10	955 Rumsey Place					Jopp	a				H	arford
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CIT								10d, INSIDE CITY			
DIE	Maryland H	Harford			Jop	pa						LIMITS?
AL	10e. STREET AND NUMBER					ZIP CODE	E			10g. CITE	ZEN OF Y	WHAT COUNTRY?
FUNERAL		55 Rumsey Place 21085 USA							SA			
F	11. MARITAL STATUS 12  1 Never Married 2 Married	. WAS DECEDENT EVER IN U. FORCES? 1 YES	NO	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN?	(Specify Ye	s or No-	14, RACE Black	— American Indian, t, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	S			2 🔀 NO			, ,		Speci	fy:
	15. DECEDENT'S EDUCATION	ON 18	a. DECEDENT'S	USUAL O	CCUPATIO	)N		16b,	KIND OF BU	SINESS/IND	USTRY	white
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	(2016ge (1-4 or 8 +)	(Give kind of life. Do NOT u	work done ( se retired.)	during mo	st of worldn	g					
MP		1	Accou	ntan	t				Rail	L Road	f	
8	17. FATHER'S NAME (First, Middle, Lest)								ddle, Meiden			
BE	Victor (u/k)	Terry					atri			/k)		ner
٩	196. INFORMANT'S NAME (Type/Print)  M. Elizabeth Terry	7	19b. MAILING							the second such		005
	20a. METHOD OF DISPOSITION		ACE AND DATE				e, J		Mary			085
	1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemeter	y, cremetory or o	ther place)	OY37	me or	61	6/95		CATION —		ryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS		21011	22.	NAME AN	ID ADDRES	S OF FAC	CILITY				
	THE IV	1112	7									me, P.A.
$\dashv$	23. PART 1. Enter the diseases, or com	plications that caused th	e daath. Do	not enter	the mo	OKES	bury	7 Raco	d, Ab	ingdo	n, M	d. 21009
	anock, or heart fellura. Liet	only one cause on each	ilne.				,		-0 01 10ap	matory arr	,	Interval Between Onset and Death
	disease or condition resulting in death)	CARCINENT	up UT	P	211	169	25					Onset and Death
	Transiting in deatily	DUE TO (OR AS A CO	NSEQUENCE O	F):								
NO	Sequentially list conditions, b											
AT	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE O	F):								
음	CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CO	NSEQUENCE O	F):			-					
CERTIFICATION	resulting in death) LAST											
	PART II. Other algnificant conditions of	antellaction to death him		I- 16				- T				
B	PULMINDRY	Albori	_	in the un	derlying	cause g	iven in i	Part I.	PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ED		· · · · · · · · · · · · · · · · · · ·	3					-	1 TYES 2	贝NO		OF DEATH?
Σ.	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF I	DEATH YE	c $\square$ is	JO [	LINC	ERTAIN	L DX				1 YES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEA			ONC	LKIAII	1 2				
Sic		OSPITAL: Inpetient 2 ER/Outpetie	nt 3 🗆 DOA	OTHER	t: ling Home	€ SES Re	sidence	6 Other	(Specify)			
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM		28c. INJI	JRY AT				NJURY OCC	URED	
BY	1 Netural 5 Pending 2 Accident Investigation			М		ES 2	NO					
	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — building, etc. (Specify)	A1 home, farm,	street, facto	ory, office			28f. LOCAT City or	ION (Street ( Town, State)	and Number	or Rural R	oute Number,
AP	29a. CERTIFIER (Check only one)											
COMPLETED	2 MEDICAL EXAMINER: 0	n the basis of examination an	d/or investigation	n, in my o	pinion, de	with occur	ed at the t	time, deta a	nd placa, an	d due to the	Cause(a	and manner as stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIER	0	10,9			29c. LICE	NSE NUM	BER	77	29d. DATE	SIGNED	(Month, Day Year)
2	30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF DEATH	11 L	Owine's		IJ	0	7-70	2	6-	3-	75
	Louis C. BANS	chi Mn	— 9		R	kbn	Kli	7	Po.	pal	VE	Mold
	31. DATE FILED (Month, Day, Year)  JUN 06 1995	22. REGISTRAR'S SIGNATU	RE					-	<b>J</b>			
	4 1000		CACCAGE									



FOR STATE

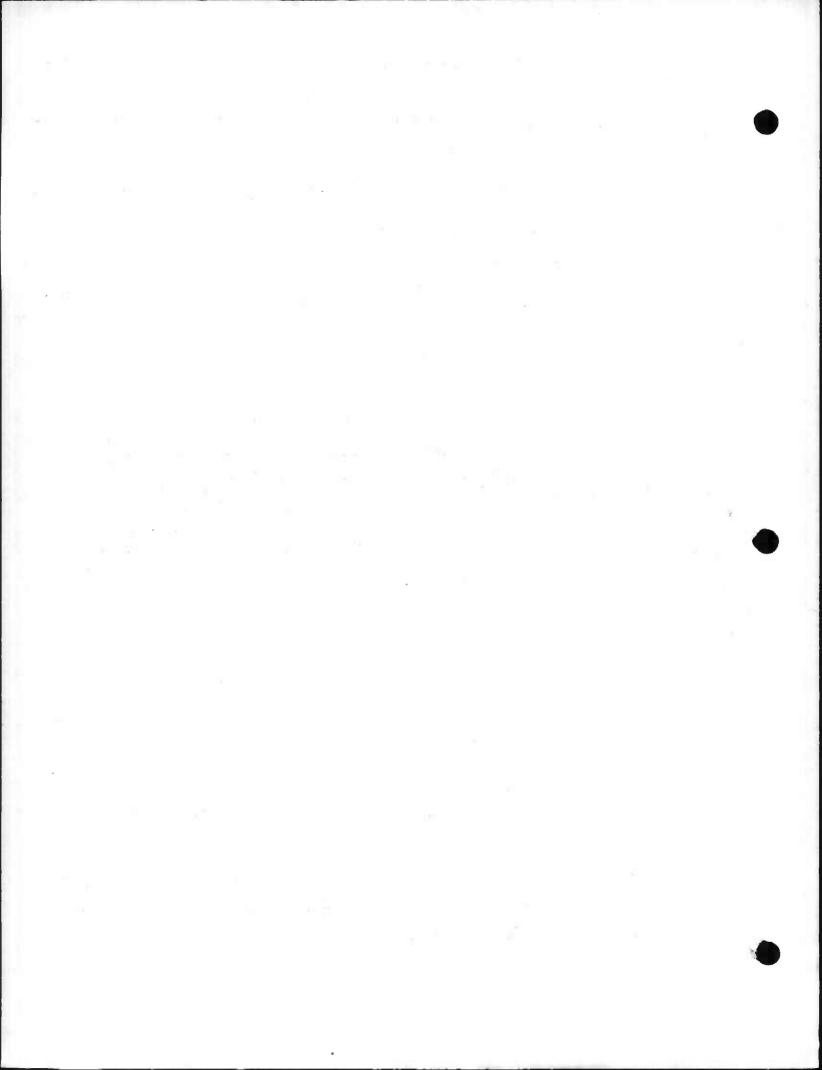
Amended Item # 12 WCHD 6/8/95 jrd

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	ROBERT	,				2. DATE OF DEATH		
H 4. 5			EMEYER				31 19	
	SOCIAL SECURITY NUMBER	1 🛛 M 2 □ F 62	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) 9-20-193	2 M	BIRTHPLACE (State or Foreign Country)
ε D	FACILITY NAME (If not institution ENINSULA RE	GIONAL MEDIC	CAL CT.		N OR LOCATION OF DI	EATH	Se. COUNTY WICC	OF DEATH OMICO
S	. STATE 10b. C	OUNTY Wicomico		y, town on Lo elmar	CATION			10d. INSIDE CITY LIMITS?
10e.	STREET AND NUMBER	WICOMICO		elmai	10f. ZIP CODE		10g, CITIZEN	1 YES 2XXNO
FUNERAL	9298 Colonial	Mill Drive		- 1	21875		USA	
ã <b>60 3</b> L	MARITAL STATUS  Never Married 2 X Merried  Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	DATES	If yes,	ecendent of Hispan specify Cuban, Mexica ES 2X NO Specifi	in, Puerto Ricen, etc.)	fea or No — 14.	RACE — American Indian, Black, White, atc. Specify: White
LETED	15. DECEDENT (Specify only highes	S EDUCATION	16a. DECEDENT'S	work done during	TION most of working	16b. KIND OF B	USINESS/INDUST	TRY
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Road M	∞ retired.) echanic		McTntv	re Faui	pment Co.
	FATHER'S NAME (First, Middle, Le					ME (First, Middle, Melde		pinetre co.
# III	Harry Thiemey					Allen Thi	2	
≅ I O II	.informant's name (Type/Prin Janet Markle ]	ř.			et end Number or Aural 1 Mill Dr			
A 20a	METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION	(Name of		OCATION - City	
Ē 40	Buriel 2 Coremetion 3 Donetion 5 Other (Specify	)(	metery, crematory or d Cambridge				mbridge	, Md.
21. 5 10. 5 21. 5 23. 5	SIGNATURE OF FUNDRAL SERV	M, John		Sho	and address of FA rt Funera E. Grove	1 Home, I		19940
r other traumatic event, the rest can sea sea sea sea sea sea sea sea sea sea	MEDIATE CAUSE (Final lease or condition witing in death)  quentially list conditions, say, leading to immediate use. Enter UNDERLYING USE (Disease or injury at initiated events witing in death) LAST	b DUE TO (OR AS	A CONSEQUENCE O	F): F):	RXID DU	NO HULTI	Phi Thy	Onset and Death
ICAL IN IN IN IN IN IN IN IN IN IN IN IN IN	RT II. Other significant con	ditions contributing to death	but not resulting	in the Underly	ing cause given in	Part I. 24a. WAS A PERF	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	ND TOPACCO LICE CO	ON ITRIDITY TO CALLEY	25.054711 200					1 TES 2 NO
PHYSICIAN:	WAS CASE REFERRED TO MEDIC	ONTRIBUTE TO CAUSE (	28. PLACE OF DEA		UNCERTAIN	N LJ		1000
YSICI,	XXYES 2 NO	HOSPITAL: 1 Inpetient 2XXR/Out	Ipatient 3 🗆 DDA	OTHER: 4 Nursing H	ome 5 - Residence	6 Other (Specify)		
Harked, 1	MANNER OF DEATH  Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	A-	URY	NJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUR	ED ?Actus
S Mar	Accident Investig	28e. PLACE OF INJUR	Y — At home, ferm,	71-	YES 2 NO	281. LOCATION (Street		PUCK, PCK, XUPPE
m 28	Homicide determin		LSITE			SOGERDI	FOSney	LY DECHAR HD
THE 13 200.		PHYSICIAN: To the best of my know						
COMPL	2 K MEDICAL EX	AMINER: On the besis of exemination	on end/or investigation	n, in my opinior	, death occured at the	time, date end place,	end due to the ce	suse(s) end manner as stated.
D BE CO	MANAST	The ULIL			29c. LICENSE NUM			GNED (Month, Day, Year)
	NAME AND ADDRESS OF PERSON		EATH (ITEM 27) (Type)		O.C.Met, Balt			NE 1,1995 nd 21201
14	DATE FILEO (Month, Day, Year)	3.1.0.0	NATURE WAR					

BALTIMORE, MARYLAND 21215-0020

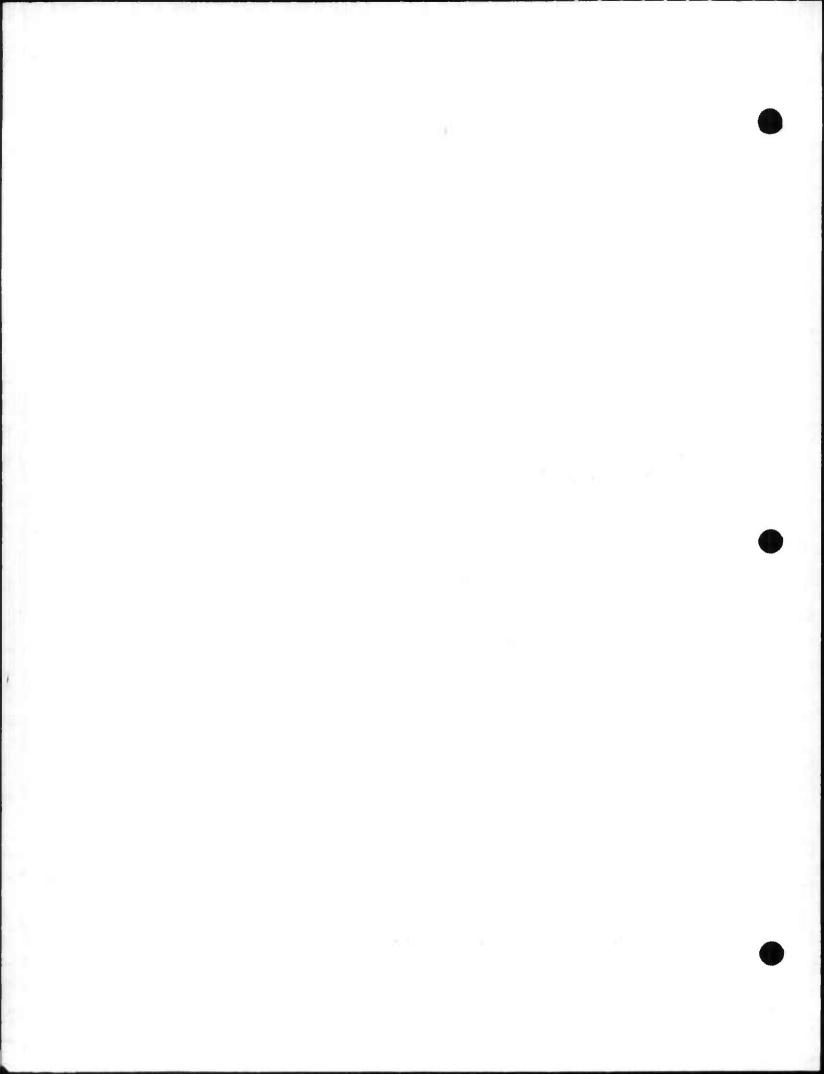
DIVISION OF VITAL RECORDS, P.O. BOX 68769



DHMH-16 Rev 1/89

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		1 - STATE REGISTRAR	STATE OF MARYLAND / DECER	PARTMENT OF HEA	LTH AND MEI	NTAL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	2 Take	h		DATE OF DEATH DAY	95	3. TIME OF DEATH
pin		004 40 0400		RS. MONTHS DAYS HO	DURS MIN. 1	DATE OF BIRTH (MONTH, Day, Year) 0/7/1926	Wilmi	ington, DE
1, 2, 3 should	TOR	Union Hospital	ix and number)	eb. CITY, TOWN OR LC Elktor		9c. (	Cecil	ATH
permit. Pages	DIRECTOR	Delaware New (		c. CITY, TOWN OR LOCATION Newark				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
an. Transit per	FUNERAL	1102 Chelmsford C			9713		USA	
5-0020 ding physician. the burial-transit	BY	1 Merer Merried 2 Merried  3 SWWidowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 □ ND IF YES, GIVE WAR OR DATES		Cuban, Mexican, Pt	RIGIN? (Specify Yes or No- erto Rican, etc.)	- 14. RACE - Black, Specify:	- American Indian, White, etc.
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burian notified at once.	COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) 12	mpleted) (Give ki ife. Do life	ENT'S USUAL OCCUPATION and of work done during most of VOT use retired.)	working	Cosmetic & Manufac	k Perfu	
RYLAND of by the hospit of be detached of at once.	BE CO	17. FATHER'S NAME (First, Middle, Last) Albert Takach			Elizabetl	First, Middle, Meiden Surnen n Pass	ne)	
	5	Joyce C. Logan -	Daughter 23	Arbutus Str	eet, Elk	ton, MD 2	1921	
BALTIMORE, er death. Page 6 may be the funeral director. page val.		1XC Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	gracela	or other place) Wn   Memorial	1	5/26 New C	astle,	Delaware
0 = 0	9	21. SIGNAP AS OF FUNERAL SERVICE LICENTARY C. Mayer		Spicer- 1000 N	Mullikin DuPon	Funeral Ho t Pkwy,Nev	v Castl	nc. e DE 19720
68760 Becuted within 24 hours after and completely filled in by the burial, cremation, or removatic event, the medical		23. PART i. Enter the diseases, or conshock, or heart failure. List immediate CAUSE (Final disease or condition resulting in death)	A S C V D  DUE TO (OR AS A CONSEDUEN	ICE OF):	of dying, such as	cardiac or reapiratory	srrest,	Approximate interval Between Onset and Daath Years
SOX ite be en prior to traum	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEDUENCE CARDIAC ARE DUE TO (OR AS A CONSEDUENCE ARE DUE TO (OR AS A CONSED	CE OF):				Hour.
P.O. h certiff anding property Hygien	CERTIF	that initiated events resulting in death) LAST		INFARCE	TON			54RS.
RECORDS, I requires that the deat een signed by the atter of Health and Mental shows any injury,	MEDICAL	PART II. Other significant conditions				PERFORMED?	, A	VERE AUTOPSY FINDINGS MARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO
TAL The law te has b ate Dept.	SICIAN:		26. PLACE OF	DEATH (Check only one)	JNCERTAIN [		<u> </u>	
OF V PHYSICIAN this certifi with the i	РНУ	27. MANNER OF DEATH  1 Netural 5 Pending	Inpatient 2 VER/Outpetient 3 □ D  28e. DATE OF INJURY (Month, Dey, Year)  28i	OA 4 Nursing Home 5  D. TIME OF 1NJURY WORK?  M 1 YES	AT 28d	Other (Specify) . DESCRIBE HOW INJURY	OCCURED	
OR ATTENDING ID DIRECTOR: After hours after death item 28 is mai	TED BY	2 Accident investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At home, is building, etc. (Specify)	erm, street, factory, office	281.	LOCATION (Street and Nun City or Town, State)	nber or Rural Rou	rte Number,
425	COMPLET		IN: To the best of my knowledge, death of On the basis of examination and/or investigation.					and manner as stated.
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: I	O BE C	296. SHOMATURE AND TITLE OF CERTIFIER		Z	3504	40 ≥ 29d. 1	DATE SIGNED (A	Aorth, Day, Year)
	7	30. MAME AND ADDRESS OF PERSON WHO CO	+cliff.m.	D. 106	Bow	St E	IKTB	N. Md
		31. DATE FILED (MORITY, Day, 1607) 2 1995	32. AUGISTRAS'S SIGNATURE JULIA ATBUMBANKA	.11.				



Pages 1, 2, 3 should permit. use as the burial-transit retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 page 5 should be detached for 2 death. Page 6 may funeral director, e executed within 24 hours after d in and completely filled in by the to burial, cremation, or removal. BOX 68760 attending physician a ental Hygiene prior to requires that the death certificate be P.O. the atter DIVISION OF VITAL RECORDS. by and Signed Health a t. of has by Dept. AND. HOSPITAL OR ATTENDING PHYSICIAN: The certificate I the this c After DIRECTOR: Afr hours after de-Item 28 Is r FUNERAL DIRECT within 72 hours a To the Hospita
To the Funeral
De filed within 72
IMPORTANT: II

31. DATE FILED (Month, Day, Year)

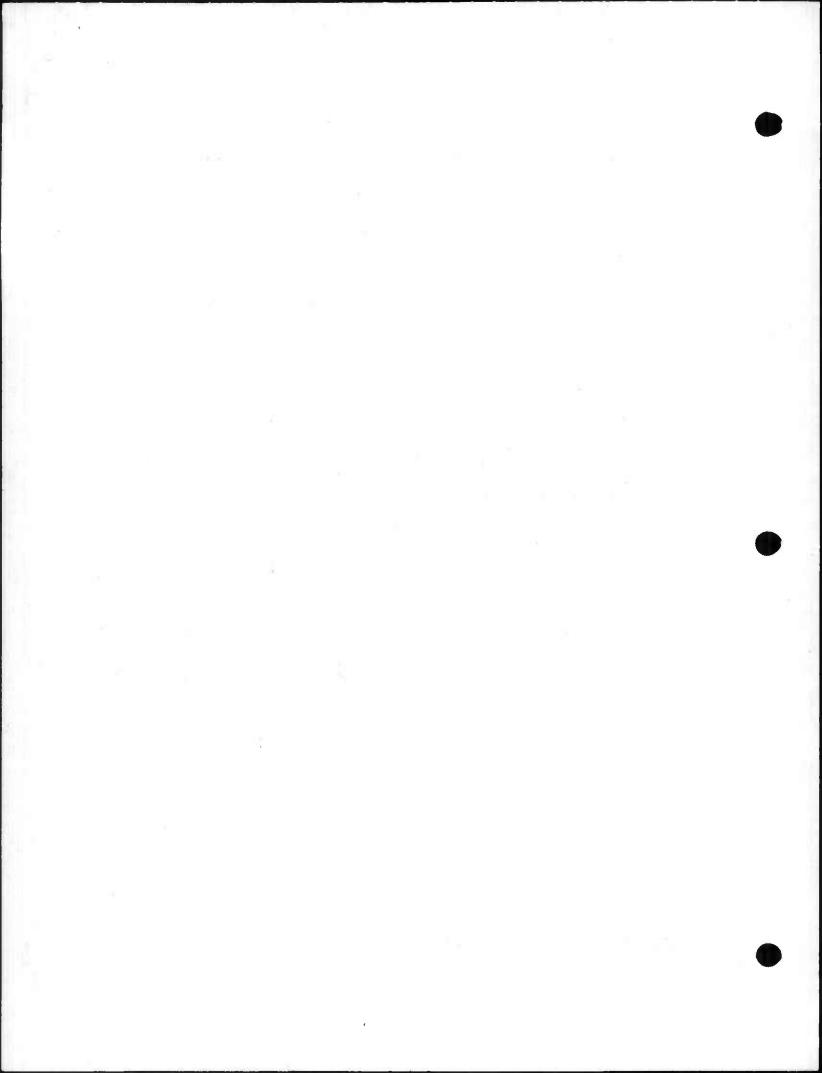
1995

32. REGISTRARYS SIGNATURE Davidson Radall

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MICHAEL MAY TERESI 95 6:30 P.M 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS 577-96-1622 1 K M 2 | F 27 YRS. October 1,1967 Washington, DC 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 10912 FRANK TIPPETT ROAD UPPER MARBORO PRINCE GEORGES 10b. COUNTY 10c. CITY, TOWN OR LOCATION County 10d. INSIDE CITY LIMITS? Maryland Prince George's Cheltenham 1 YES 2 K NO FUNERAL STREET AND NUMBER 10f. ZIP CODE United States 10912 Frank Tippett Road 20623-1320 of America 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc. IF YES, GIVE WAR OR DATES 1 YES NO BY Specify: 3 Widowed 4 Divorced White 50 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specifi H ndary (0-12) College (1-4 or 5+) COMPL Painter Commercial Painting once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Teresi 76 Jackie Davis BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John Teresi 1639 North Bumby Avenue, Orlando, FL 32803 9 20a. METHOD OF DISPOSITION
1 □ Burial 2 ◯ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 594359 must Baldwin-Fairchild Crematory 1995 4 Donation 6 Other (Specify) Orlando, Florida 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner #M00690 22. NAME AND ADDRESS OF FACILITY
Capitol Funeral Service 7213 Lee Highway, Falls Church, VA 22046 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one ceuse on each line interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) COMBINED DRUG INTOXICATION event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST 6 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? amy 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 X YES 2 NO 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 6 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 28d. DEȘCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 3:45 PM UNKNOWN 5-21-95 1 YES 2 XXNO BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 10912 FRANK TIPPIT RD. 3 Suicide 8) Could not be COMPLETED 4 Homicide UPPER MARLBORO, MARYLAND FOUND: RESIDENCE 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 15 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATIONE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. MAY 22,1995 cur 9 HE HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH WEN 27) (Type, Print)

DHMH-16 Rev 1/89

111 PENN STREET BALTIMORE, MARYLAND 21201



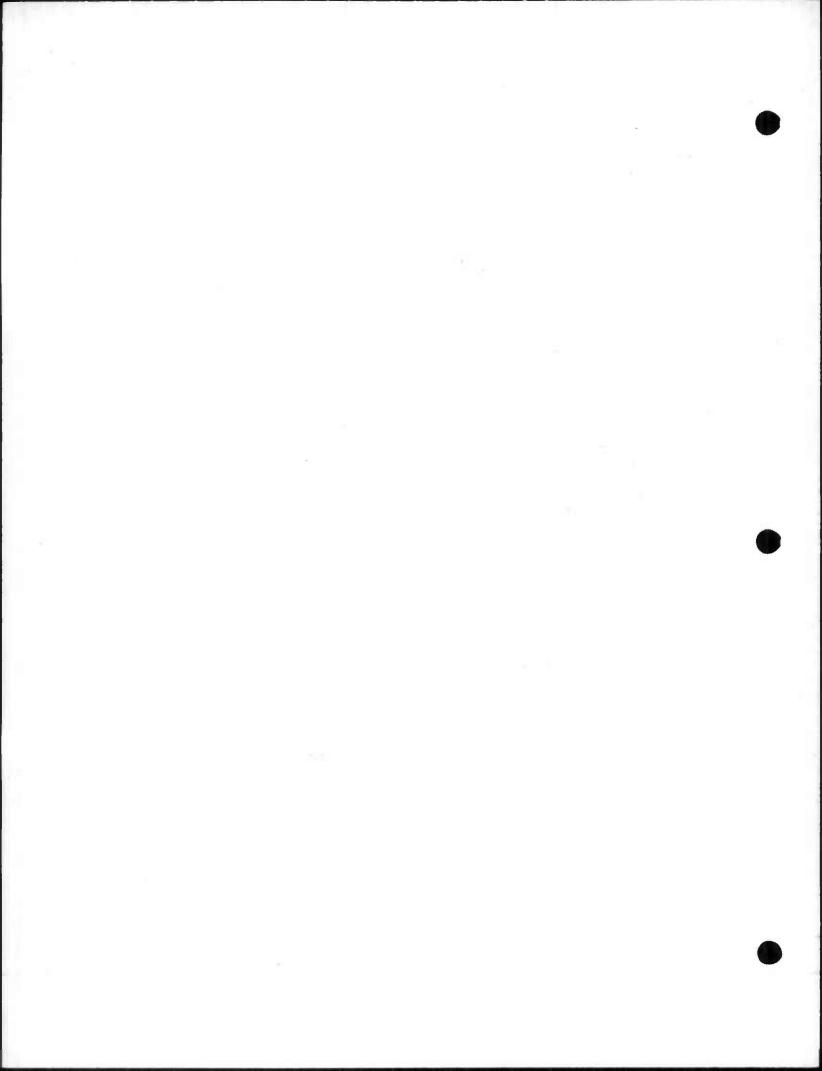
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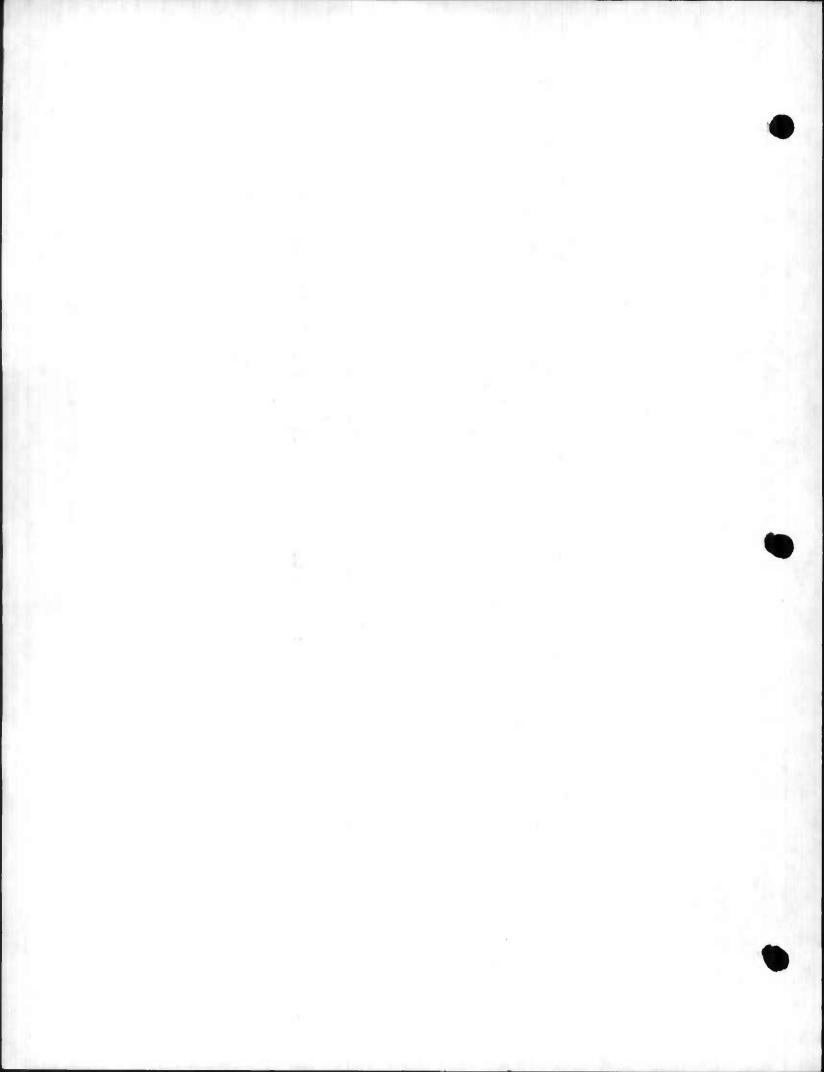
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  $_{\scriptscriptstyle N}$ 

e-	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY Y	3. TIME OF DEATH
	Dorothy I.	Thomas				May 2		995 7:00 AM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
	578-28-9991	1 🗆 M 2 🖾 F	76 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Feb. 22, 1	919 M	Country)
1_	9s. FACILITY NAME (If not institution, give s	treet and number)	20785	9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY	Y OF DEATH
DIRECTOR	8634 Reicher St	t. Landove		Land	over		Pri	nce George's
5	RESIDENCE OF DECEDENT  10s. STATE 10b. COUNTY							
<u>E</u>			100	Y, TOWN OR LOCAT	3.759			10d. INSIDE CITY LIMITS?
	Ma Prin	nce George	e's I	andove			1	1 TYES 2- NO
A A					. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
FUNERAL	8634 Reicher St				20785			.S.A
	1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 YE		If yea, sp	ecify Cubsn, Maxica	VIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No- 14	I. RACE — American Indian, Black, Whits, etc.
BY	3 Wildowed 4 🙀 Divorced	IF YES, GIVE WAR OF	DATES	1 TYES	2 NO Specif	y:	- 1	Specify:
0	16. DECEDENT'S EDUC	CATION		USUAL OCCUPATION		16b. KIND OF BU	SINESS/INDUS	Black
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of life. Do NOT u	work done during mo se retired.)	st of working			
를	1.2+h		Proce	Operato		0-	varnm	
ő	17. FATHER'S NAME (First, Middle, Last)			TIPE ALL		ME (First, Middle, Maiden		ent
ш	John D. Thomas				Marer E	lla Marsi	-11	
10 B	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip Co	ode)
۱ř	Reverly Brown		9001	Ardmore	Tando	Ma	2070	5
1	20s. METHOD OF DISPOSITION 1 O Burisl 2 Cremetion 3 Harm		20b. PLACE AND DATE	OF DISPOSITION (No	rme of	DATE 20c. LO	CATION — CIty	y or Town, Stats
1 0	4 Defiation 5 D Other (Specify)	1	cemetery, crematory or c	ther place) Memoria	1 Park	May26 L	andov	or Md
1	21. GIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AN	NO ADDRESS OF FA	CILITY		
	N/- X	/				ns Funera		
$\vdash$	23. PART I. Enter the diseeses, or o	complications Providen	and the death. De	7474	Lando	ver Rd.	Lando	ver. Md. 207
	shock, or heart fellure.	List only one ceuse or	eech line.	not enter the mo	de ot dying, suc	n aa cardisc or raspi	ratory erres	t, Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	A	4					Onset and Death
	reaulting in death)	DUE TO (OR A	& A CONSEQUENCE O	D.				weeks
-			rerebrova		, , ,	-+		
ō	Sequentially list conditions, If any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	F):	Y CC I CX CE	11.17		years
CERTIFICATION		buserte	معداك					de cades
Ē		c typerter	S A CONSEQUENCE O	F):				Decames
居	reaulting in deeth) LAST	d						
	PART II. Other significant condition	a contribution to death	but not resulting	la Aba condicional	2005-000-00	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		
EDICAL		a contributing to deet	out not reediting	in the underlying	g ceuse given in	Part i, 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă	Mone					1 [] YES 2	MO	OF DEATH?
Σ	DID TOD 1 660 1165 601 117				/			1 TYES 2 NO
AN	DID TOBACCO USE CONTR	RIBUTE TO CAUSE			UNCERTAIL	10		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:				
ΥS	1 YES 2 NO	1 inpetient 2 ER/O		4 - Nursing Hom		8 Other (Specify)		
	27. MANNER OF DEATH  1 Natural 5 Pending	28s. DATE OF INJUR (Month, Day, Year		URY WO	RK?	28d. DESCRIBE HOW I	NJURY OCCUR	RED
B	2 Accident Investigation	00- 51 405 05 51 11	-		ES 2 NO			
	3 Suictde e Could not be	building, atc. (S	RY — At home, farm, pecify)	street, factory, offici		28f. LOCATION (Street a City or Town, State)	and Number or .	Rural Route Number,
ᇤ	29a. CERTIFIER							
절	(Check only   CERTIFYING PHYSIC	CIAN: To the best of my kn						
COMPLET	2 MEDICAL EXAMINE	R: On the basis of sxamine	tion and/or investigation	n, in my opinion, d	eath occured at the	time, dats and place, an	d due to the c	ause(s) and manner as stated,
BE (	296. SHOMATUME AND TITLE OF CENTHRICH				29c. LICENSE NUM		29d. DATE SI	IGNED (Month, Day, Year)
0	les yhlen	a			022	750	15/2.	3/95
	30. NAME AND ADDRESS OF PERSON WHO	100	DEATH (ITEM 27) (Type	Print)		Green belt.	110 -	226
-						7 00 - 1 0 ff	MN 7	
	Peter M. Schissler			a way	14.	HER SELT	, , , ,	0110
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SI	GNATURE	n way	14.	New Set T	, .4 .	0+10



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SIVISION OF VITAL RECORDS, P.O. BOX 68760

L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	Dermit.		
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH YEAR 995 8347 MONTH NORA HOMAS 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HMS. 8. BIRTHPLACE (State or Foreign 169 1 M 2 KF DAVE HOURS WADE Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1ARBOR DIRECTOR HARBOR HOSPITAL BALTIMORE ENTER BALTIMORE 10a. STATE 10c, CITY, TOWN OR LOCATION MD BALTIMORE BALTIMORE 1 YES 2 NO 10a. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 206 SEAGULL AVE APT 2 21225 U.S.A. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 TYES 2/CHOO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY Specify: BLACK 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) College (1-4 or 5+) MD.GENERAL HOSPITAL N/A HOUSE KEEPER 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at N/A BE BERTHINA EVANS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 WALTER THOMAS 206 SEAGULL AVE. must be 20e, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION --- City or Town, Stata cemetery, crematory or other place) 4 Donation 5 Other (Specify) ROCKFISH CEMERERY
22. NAME AND ADDRESS OF FACILITY COLOMB 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner THE HOUSE OF WILLIAMS 11 ST medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death 9 ashi disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF) event, CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS ardiomodeth MAILABLE PRIOR TO COMPLETION OF CAUSE Яше 1 YES 2 NO 1 1 YES 2 | NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY -- At home, farm, street, factory, offica building, stc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) -COMPLETED 8 Could not be determined 28 4 Homicide 29a. CERTIFIER 1 DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and pieca, and due to the cause(s) and manner as stated, TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 M. IMPORTANT: If IN 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFICE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day Year) BE 1) 23824 2

S-CRAIN

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HICHWAY

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

who Davidson Rardall

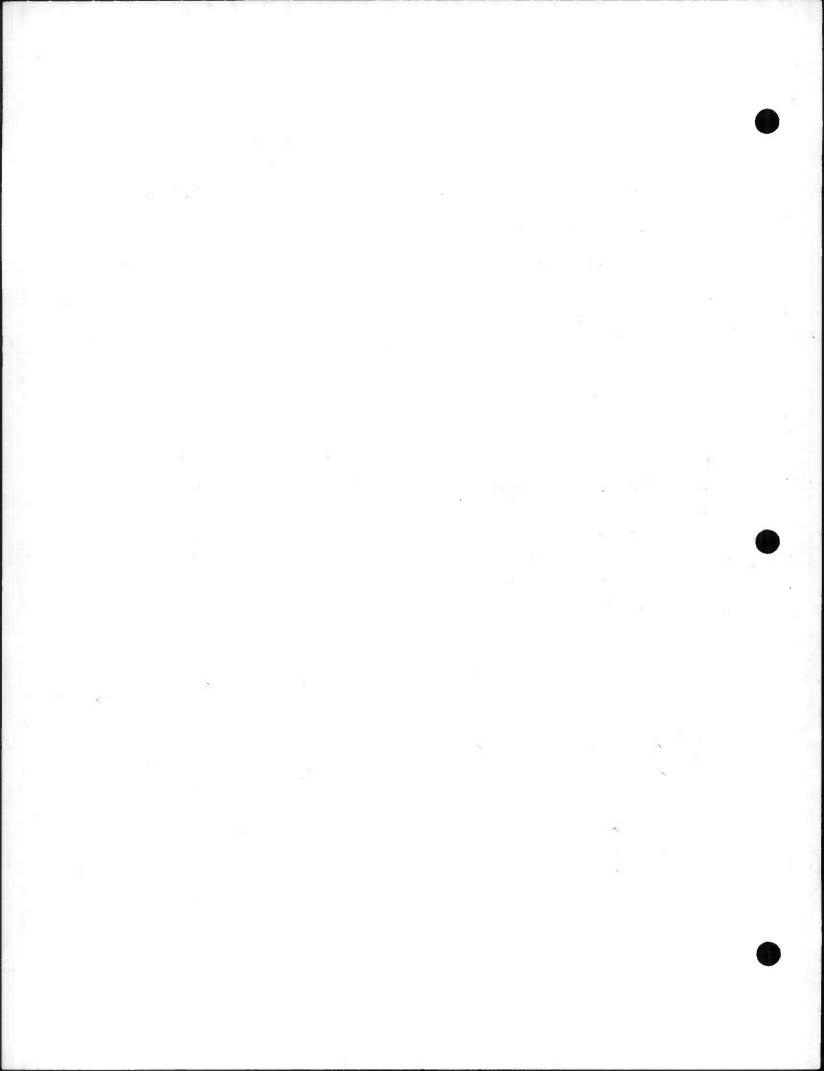
B. KHANDELWAZ, M.D

31. DATE FILED (Month, Day, Year)

3 v 1995

DHMH-18 Rev 1/89

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MINDOTANT H from 28 to marked as from 22 shound any injury, as other tenuments among the marked as an extension and the market of the same to the same
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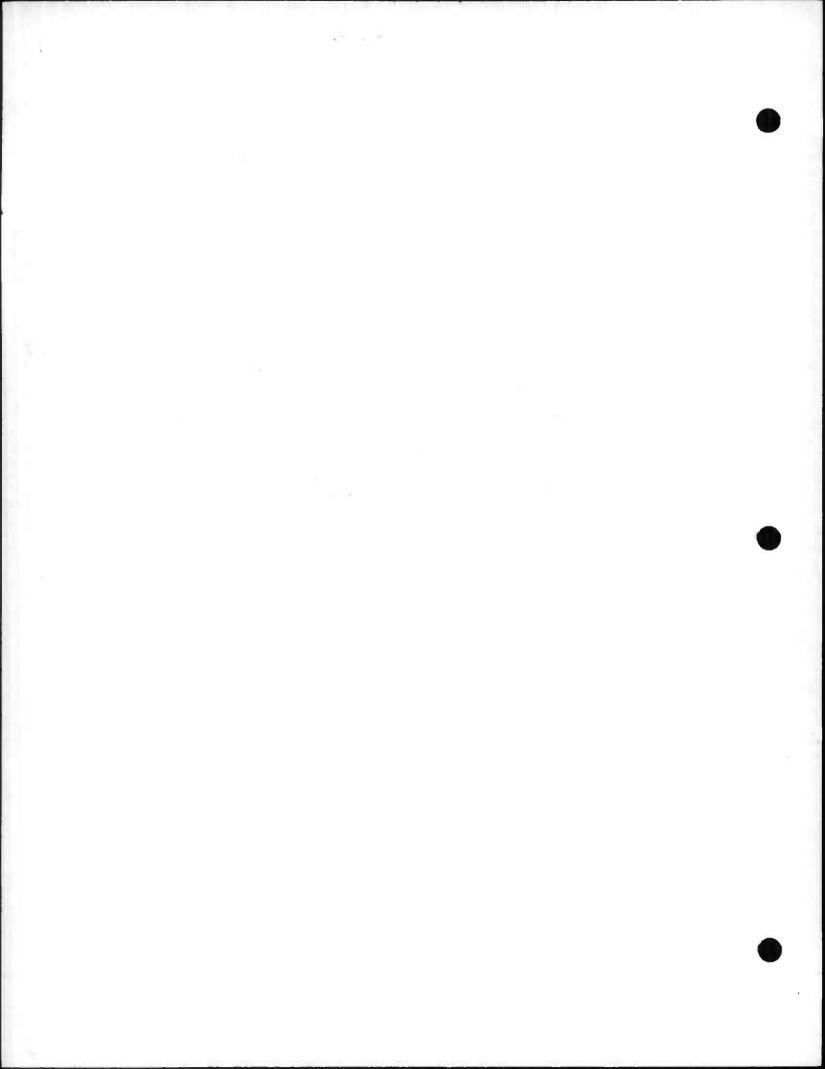
31. DATE FILED (Month, Day, Year)
JUN 0 9 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 11:30PM E DWARD JUNE 6,1995 TROTTER, JR. HOWARD 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 7<sup>™</sup>23-1922 July HOURS DAYS 214-18-8931 MARYLAND 1 X M 2 - F 72 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WALDORF CHARLES 3763 OLD WASHINTON ROAD RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. **CHARLES** WALDORF 1 YES 2 1 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3763 OLD WASHINGTON ROAD 20602 USA -UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES GIVE WAY OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TYES 2 NO BY Specify: 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ndary (0-12) lege (1-4 or 8 +) 11 grades - 0 -District Superintendent Commercial - Electric 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Howard Edward Trotter, Sr. Margaret Ellen Railey BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Howard Edward Trotter, III 9339 WINKLER Lane, La Plata, Md. 20646 20s METHOD OF DISPOSITION 1 Burlal Gramation 20h. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Triffity Mem. Gardens S/ Other (Specify) 6/9/ Waldorf, Md. FUNERAL SERVICE LIGENSEE The Huntt Funeral Home, Inc. M00053 Mark Brohawn P.O. Box 156, Waldorf, Md. 20604 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch ea cardiec or respiratory errest, Approximate shock, or heert fellure. List only one ceuse on each line. interval Bety IMMEDIATE CAUSE (Final Onset and Death disease or condition CANER OF LUNG resulting in death) DUE TO (OR AS A CONSEQUENCE OF): OF ESOPHARUS CANCER CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in deeth) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TES 200 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 TYES 2 NO HOSPITAL: OTHER: Inpetient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 27 MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT-28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation М 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a. CERTIFIER LECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attend. ion end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 95 0 D-28352 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

KRISHAN MATHUR MD 11340 PEMBROOKE SQUARE SUITE 213 WALDORF MD. 20603

32. REGISTRAR'S SIGNATURE

Jalia Davilson Revolate



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local feath feath. Page 6 may be retained by the hospital or attending physician.

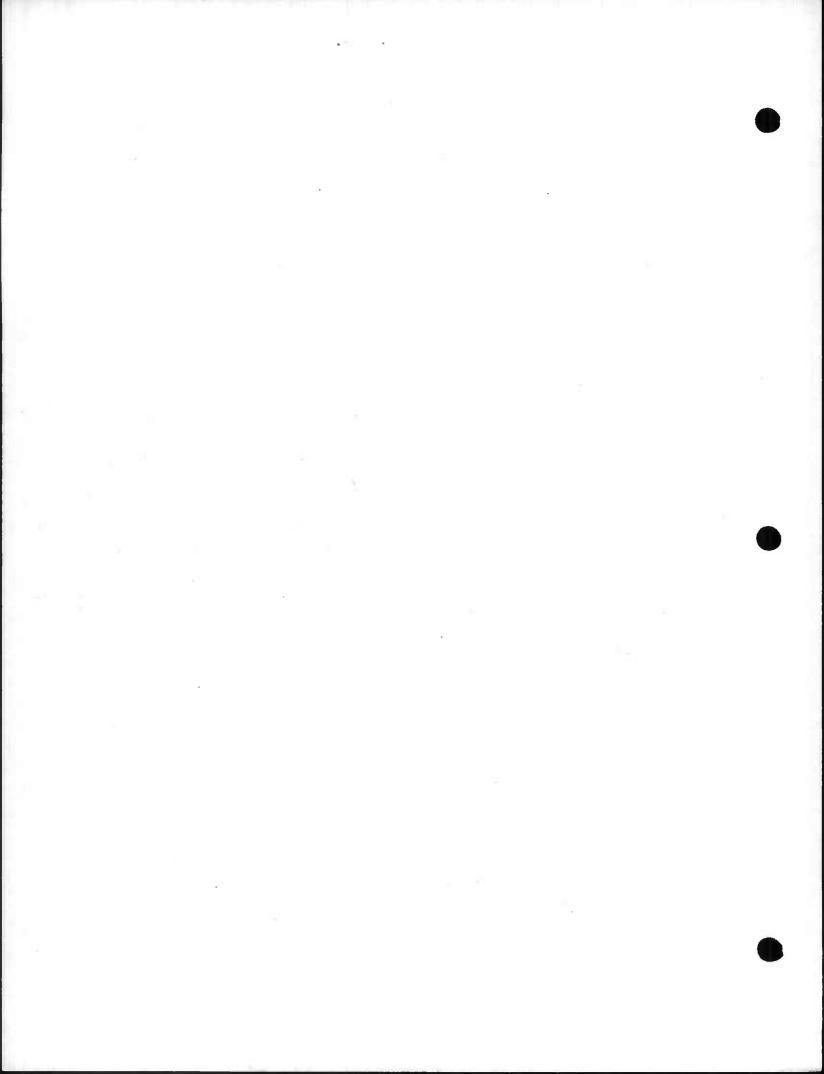
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. OECEDENT'S NAME (First, Middle, Last)													
	1. DECEDENT'S NAME (First,									2. DATE OF OE	DAY	YEAR	3. TIME OF OEATH	
		Clif	ford Geo	orge Var	Sickle					MAY 31 1995 3:55				
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER				7. DATE OF BIRTH			THPLACE (State or Foreign	
	214-52-1910		1 🔀 M 2 🗆 F	45	YRS.	MONTHS	MONTHS DAYS HOURS MIN. (Month, Day, Year)					Country)		
	9a, FACILITY NAME (If not in		treet and number)			9h CITY	TOWN	R LOCATI	ON OF OR		9c. COUNTY OF DEATH			
œ	Sacred Hear								0.00		-			
6	RESIDENCE OF DEC		Ital			Cumberland						Alle	gany	
DIRECTOR	10a. STATE	10c. CIT	Y, TOWN (	OR LOCAT	ION			-		10d. INSIDE CITY				
<u> </u>	Maryland	Gra	antsv	7i 11	2					LIMITS?				
	10e. STREET AND NUMBER	Garre			1 010	21100							1 TES 2 NO	
A		1 Dend	,				101	ZIP COO			10g. CITIZEN OF WHAT COUNT			
FUNERAL	Dorsey Hote	I KOAO						215				USA		
5	11. MARITAL STATUS 1 Never Married 2 X	Mondad	12. WAS DECEDER	T EVER IN U.S. A		13.	WAS DEC	ENOENT C	F HISPAN	IIC ORIGIN? (Spec	Ify Yes or N	o- 14. RA	ICE — American Indian, ack, White, etc.	
IF YES, GIVE WAR OR OATES  1 YES 27 NO Specify:											16.7		ec/ly:	
						1						w]	hite	
Ē	15. DEC	EDENT'S EDU	CATION completed)		ECEDENT'S				na	16b. KIND (	OF BUSINES	S/INDUSTRY		
Щ	Elementary/Secondary (0	-12)	College (1-4 or 5	+}	e. Do NOT u	se retired.)				10.5				
P P	12 th			Tim	ber o	opera	ator,	/10gg	ger	Tim	er			
COMPLETED	17. FATHER'S NAME (First, Mi	iddle, Last)						16. MOT	HER'S NA	ME (First, Middle, A	faiden Sums	ime)		
	Raymond Cli:	fford	VanSick1	.e				Mal	cel 1	Eleanor	Teat	S		
BE	19a. INFORMANT'S NAME (7)	vpe/Print)		1	9b. MAILING	ADDRESS	S (Street a	nd Number	or Rural F	Route Number, City	or Town. Sta	te Zin Code)	21526	
2	Sylvia J. V	anSick	1e										21536 ville, MD	
	20a, METHOD OF DISPOSITI			20b. PLACE					Jey .			ON — City or		
	XXBurial 2 Cremation		oval from State	cemetery, co	ematory or o	ther plece	omo	CETE	Tuna	2 05 1	e count	Acres 1	1 a MD	
	12. NAME AND ADDRESS OF FACILITY												re, MD	
- 1	. 10	0	n							al HOmes	s. P.	Α.		
	- XV	Suc	1 kuns	aw						t., Gran			MD 21536	
	23. PART I. Enter the di	senses, or o	ompfications the	1 caused the d	eeth. Do i	no1 enter	the mo	de of dy	ng, aucl	n an cerdiec or	respiretor	ry srrest,	Approximate	
	IMMEDIATE CAUSE (Fin		List only one ce	ase on each lin	е.	1	. 1	. 1				0	Interval Between Onsat and Death	
	disease or condition	lai.	2.1	V. —	+100	1.0	1 1	). I	, .	1 1	)	V .		
- 1	reaulting in death)			OR AS A CONS	TA-			(nt	ria	rau H	rrhy	oh mic	a 5 min.	
_ 1														
6	Sequentially list conditi		b. P) I L)	OR AS A CONSE	PATO	10 1	240	DAC	ny				5 years	
F	if any, leeding to immed cause. Enter UNDERLYI				Λ	T	OG	1).	61				Q I	
유미	CAUSE (Disease or Inju		COTO	OR AS A CONSE	MY.	FCY		V18	EC62	e			3 years	
Ē	that initiated events resulting in death) LAS'	r 1	OUE TO	(On AS TOOMS	OUENCE U								0	
CERTIFICATION			d											
	PART II. Other significa	nt condition	a contributing to	death but mot	reaulting	In the ur	derlyln	cause	alven in	Part I. 24a, W	AS AN AUTO	OPSY 2	4b. WERE AUTOPSY FINDINGS	
EDICAL	7 1	betes	10							P	ERFORMED	3	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
		1		TI EN	3.					—   ¹º'	ES 2 N	10	OF DEATH?	
Σ		CYTCY	sion,							_			1 TYES 2 NO	
Ž														
ਹੈ	25. WAS CASE REFERRED TO EXAMPMER?	MEDICAL	HOSPITAL:			OTHE		ACE OF D	EATH (Che	ack only one)				
I S	1 NYES 2 1 NO		1 Inpetient 2	ER/Outpatient	3 🗆 DOA			e 5 □ Re	aldenca	8 Other (Specia	y)			
PHYSICIAN:	27. MANNER OF DEATH		26a. DATE OF		28b. TIM	IE OF JURY	28c. INJ WO	URY AT RK?		28d. DESCRIBE	RULNI WOH	Y OCCURED		
BY		Pending investigation				М		ES 2	] NO					
	a Collete	Could not be	26e. PLACE (	of INJURY - At h	ome, farm,	street, fact	ory, offic			28f. LOCATION		umber or Rura	al Route Number,	
E		detarmined	bunding.	etc. (Specify)						City or Town,	State)			
9 1	29a. CERTIFIER	IEVING BUVEL	CIAN. To the head of			1,000								
₽ I			CIAN: To the best of											
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(a) and manner as stated.											e(a) and manner as stated.			
ш	29b, SIGNATURE AND TITLE	OF CERTIFIER	1/1/	0	0			29c, LICI	ENSE NUM	IBER	29d	DATE SIGNI	ED (Month, Day, Year)	
8	100	-	()	/	1	mI	)	D	34	079	•	Luno	1.1995	
임	III HAMI AND ADDRESS OF	PERSON WH	COMPLETED CAU	SE OF DEATH (ITI	M 27) (Type	, Print)		•	1			2-116	.,,,,,	
	( James	E	13c.	trel	mo	/		0- 1	151-1	110 %	りつ			
, 1	31. DATE FILED (Month, Day,		3e. REGISTR	R'S SIGNATURE				p4 -1 /	101	7 1				
0	JUN 7	1995	Jelia Me	dear Ras	all									
السن			()											



## BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

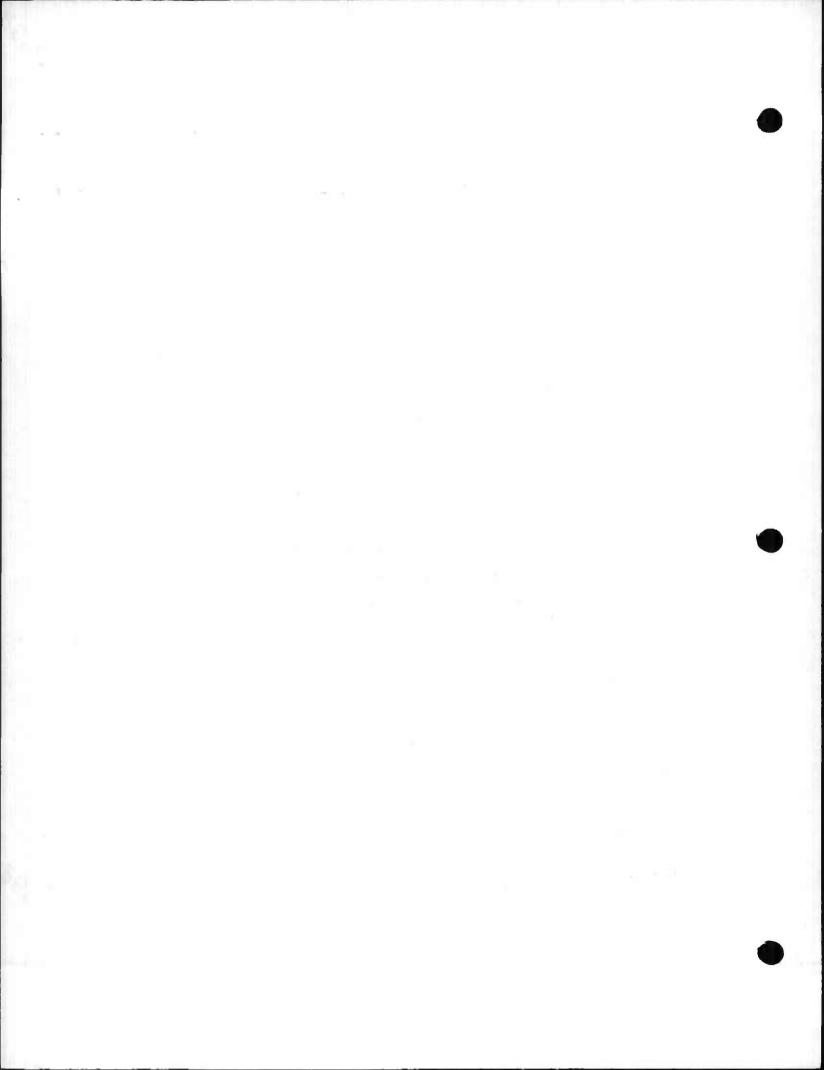
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF DEATH	1	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest)			2. DATE OF	DEATH		3. TIME OF DEATH				
	CHRISTINE KERASOTIS VIYN	100		HTHOM	DAY	YEAR					
			F UNDER 1 YEAR   IF UNDER 24	MAY HRS. 7. DATE OF			9:45a m M				
	579-12-1732B 1□M2⊠F	The second secon		(Month E	Ser Mart	Count	try)				
		13971		Nov.	21, 1923	Nev	v York				
~	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR LOCATION	OF DEATH	9c. CC	DUNTY OF	DEATH				
0	DOCTORS COMMUNITY HOSPIT	'AL	LANHAM-SEABR	OOK	DD	THE	GEORGE'S CO.				
5	RESIDENCE OF DECEDENT		EMAIN SENSI	VVIX		TIVLE	GEVRIGE'S CU				
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCATION				10d, INSIDE CITY LIMITS?				
	Maryland Carroll	Tane	ytown				1 YES 2 NO				
A	10e. STREET AND NUMBER		10f. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?				
FUNERAL	4408 Teeter Road		USA								
<u>z</u>	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14, RJ										
	1 Never Married 2 N Married FDRCES? 1	YES 2 ND	If yes, specify Cuban, it	dexican, Puarto Rici	an, etc.)	Blac	E — American Indian, ik, Whita, alc.				
B	3 Wildowed 4 Divorced IF YES, GIVE WAR	UR DATES	1 TYES 2 X ND	Specify:		Spec	White				
۱	15. DECEDENT'S EDUCATION	16a. DECEDENT'S US	IIAL OCCUPATION	16h W	IND OF BUSINESS/I	HOHETRY	WILLE				
	(Specify only highest grade completed)	(Give kind of wor	k done during most of working	100. 10	IND OF BUSINESS/I	NUUSINI					
٦	Elamentary/Secondary (0-12) College (1-4 or 5+)		naker		Own Home						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	Home									
				'S NAME (First, Mide		)					
8	Stephen Nicholas Kerasiotis			ope Vass							
2	19a. INFORMANT'S NAME (Type/Print)		ODRESS (Street and Number or								
-	John V. Viynos	4408 Te	eter Road, T	aneytown	, Maryla	nd 2	21727				
	20e, METHOD OF DISPOSITION 1 K Burlel 2 □ Cremation 3 □ Ramoval from State	20b. PLACE AND DATE OF	DISPOSITION (Name of	DATE	20c. LOCATION	- City or T	own, State				
	4 Donation 5 Other (Specify)	Harmony Hil	Alace)	5/30	Lanham,	Mar	vland				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS								
	N. 1712 > 4	,	11800 New H	Hampshire	e Avenue	ar ru	merar nome				
	Chemes XJugor	J	Silver Spri	ing, Mary	yland 20	904					
	23. PART i. Entar the diseases, or complications that ca	used the death. Do not	antar the mode of dying.	, such as cardia	or respiratory	arrest,	Approximata				
	shock, or haart failure. List only one cause	on asch ilna.					interval Between Onset and Death				
	IMMEDIATE CAUSE (Final disease or condition	00.41	TARATA.				0-				
	resulting in death) e. /// O C /-	AS A CONSEDUENCE OF	JFARC TION	J			minules				
_											
HIFICATION	Sequentially list conditions,	AS A CONSEDIENCE OF	CY DISEASE	3			yrs				
<b>F</b>	ii any, izading to immediata						1440				
	CAUSE (Disease or injury	ES MELLI	1 US				yns				
							1				
CER	d. A JPEICE	ENSION					yns				
	PART ii. Other significent conditions contributing to dea	th but not resulting in	the underlying easies also	n in Book i	- 100 0 111 117000						
N N	1901	an but not resulting in	and undarrying cause give	m in Pert I. 24	Ia. WAS AN AUTOPS PERFORMED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
5	1991, caediac bypass			1	YES 2 NO		OF DEATH?				
Z							1 YES 2 NO				
	DID TOBACCO USE CONTRIBUTE TO CAUS	E OF DEATH YES	☐ NO Y UNCER	TAIN 🗆							
SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH									
2	EXAMINER?  1 YES 2 NO  HOSPITAL: 1 Inputiant 2 ER		THER:	A 🗆 Bat. 10							
PHY	27. MANNER OF DEATH 26s. DATE OF INJU		☐ Nursing Home 5 ☐ Reside		IBE HOW INJURY O	COURTO					
	1 Netural 5 Pending (Month, Day, Ye	nujur	Y WORK?		IBE NOW INJUNY O	CCUMED					
5	2 Accident Investigation		M 1 YES 2 N								
2	3 Suicide 6 Could not be 4 Homicide determined	JURY — At home, farm, stre (Specify)	et, factory, office	26f. LOCATH City or 7	ON (Street and Numb lown, State)	er or Rural I	Route Number,				
<u>.</u>	4 _ Homoro										
2	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my	knowledge, death occurred	it the time, date and place, an	d due to the cause(	s) and manner as s	tated.					
COMPLEIED	one) MEDICAL EXAMINER: On the basis of axamin						a) end manner as stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIER										
4			29c. LICENS		29d, D/	TE SIGNED	(Month, Day, Year)				
5	Beiger MD (DMF)			925	▶ II	1 dy :	27, 1995				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O	F DEATH (ITEM 27) (Type, Pr	(nt)	, D	77 1						
	SBEKGER MD #205,	1100 WH	CONSIN AR	e Be	Mosda	, ne	1 20814				
	31. DATE FILED (Month, Day, Year) 32. BEGISTRAR'S	SIGNATURE									
N	MAY 30 1995 Julia ditu	SIGNATURE BLOOK RANGELL									
	1000 1/1										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a fire death. Page 6 may be retained by the hospital or attending physician.

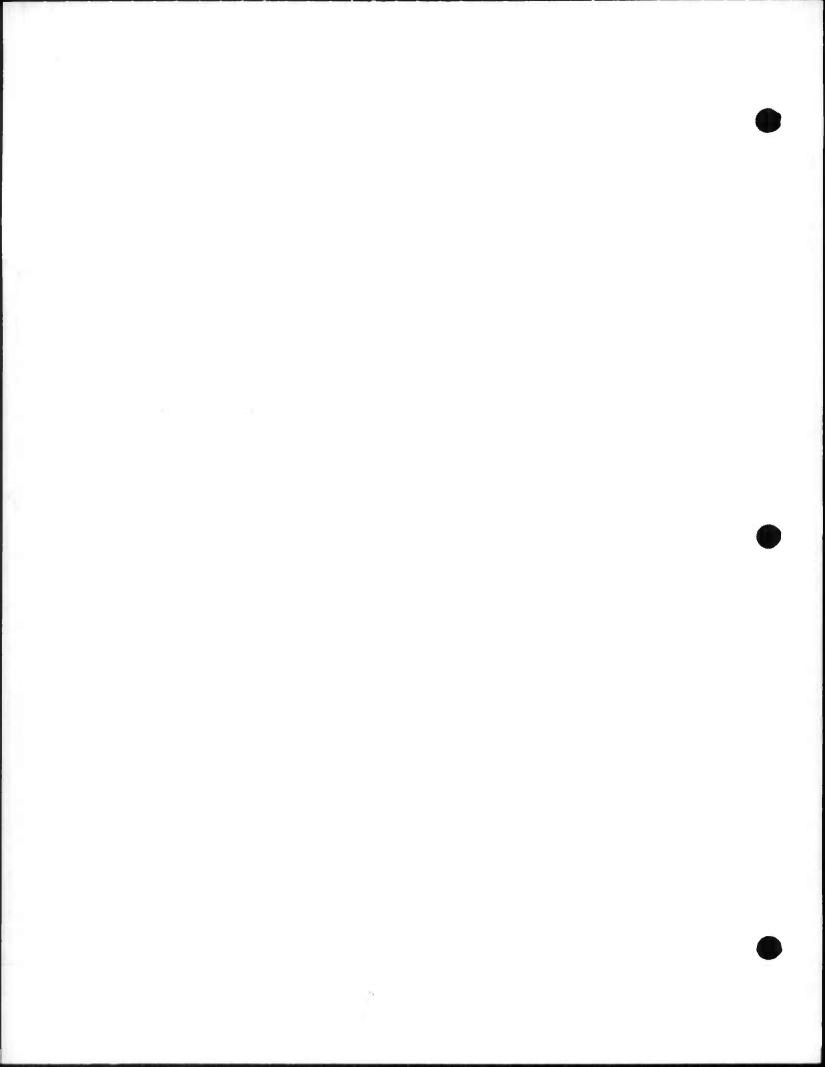
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FOR STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. N	O.					
	1. DECEDENT'S NAME (First, Middle, Last) LORENA	MAE	VANH002	'ER		2. DATE OF DEATH MAY 26,	DAY 1995	3. TIME OF DEATH 11:10 A M				
	E10 00 101L	M 2 🗷 F 82		UNDER 1 YEAR HITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 7,1		BIRTHPLACE (State or Foreign Country)     VIRGINIA				
TOR	9a. FACILITY NAME (If not institution, give street and 407 WEST DIAMOND AV		9		HERSBURG	ATH	9c. COUNTY OF DEATH  MONTGOMERY					
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND MONTGOM	IEDV		OWN OR LOCA			10d. INSIDE CITY LIMITS?					
	10e. STREET AND HUMBER		GAIT	HERSBUI 101	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
SNE	407 WEST DIAMOND AVE	AS DECEDENT EVER IN	U.S. ARMED	20877 ENDENT OF HISPAN	IC ORIGIN? (Specify		ED STATES  14. RACE — American Indian.					
BY FUNERAL	1 Never Merried 2 Merried IF	ORCES? 1 TYES YES, GIVE WAR OR DA	2 NHO TES	If yes, sp	2 NO Specify	, Puerto Rican, etc.)		Specify: WHITE				
	15. DECEDENT'S EDUCATION (Specify only highest grade complet Elementary/Secondary (0-12) Colle		16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during mo	N st of working	16b, KIND OF 8	USINESS/IND	USTRY				
COMPLETED	6	ge (1-4 or 5+)	HOMEMA	KER		OWI	MOH	E				
LAURA MYERS												
P JOHN R. VANHOOZER 1996 MAILING ADDRESS (Street and Number or Parel Route Number, City or Town, Stete, Zip Code) 4920 STRATHMORE AVENUE KENSINGTON, MD. 20795												
20s. METHOD OF DISPOSITION  1 NO Burlel 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify) BEALLSVILLE, MARYLAND												
	MURIEL H. BARBER FUNERAL HOME 20882 P.O. ROX 5038 LAYTONSVILLE MARYLAND											
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heert failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reautting in death) LAST		CONSEQUENCE OF):									
CE	PART II. Other aignificant conditions contri	ributing to death by	it not resulting in t	he underluine	seus elus la f	Sand L. Law Man						
MEDICAL	H YARRENSIVE AND	AZTER105C	LOSOTIC CAR	DIOUASI	CAR DLYG	PERF	PRMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
	DID TOBACCO USE CONTRIBUT	E TO CAUSE OF	DEATH YES	□ NO K	UNCERTAIN			1 TYES 2 NO				
HYSICIAN:		PITAL: patient 2 ER/Outpa		Check only one)  THER:  Nursing Hom	5 X Residence	C Other (Courts)						
7 I		Be. DATE OF INJURY (Month, Day, Year)	26b. TIME O	28c. INJ WO	JRY AT RK?	26d. DESCRIBE HOW	INJURY OCC	URED				
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Hornicide determined	Se. PLACE OF INJURY - building, atc. (Specif	— At home, ferm, atre-		ES 2 NO	28f. LOCATION (Stree City or Town, State	t and Number (	or Rural Route Number,				
2e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beale of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.												
O RE	30. NAME AND ADDRESS OF PERSON WAYO COMP	en und			JOZZ	87	► MA	Y 26, 1995				
	DAMES A. BRO	XUN MD	TH (ITEM 27) (Type, Pri	EDICAL	(EMER)	RUE RE	CKUIL	EM 20850				
	MAY 30 1995	2. REGISTRAR'S SIGNA						DMAM.16 Pay 1/8				



DIRECTOR

BY

COMPL

5

notified

must

examiner

Pages 1, 2, 3

permit.

CERTIFICATION

MEDICAL

PHYSICIAN:

B

COMPLETED

BE

9

3 Suicide

4 Homicide

FOR nded		16 5 STATE OF M	131/95 MARYLAND / CE	// DEPAR	1RT RTMENT	OF H	MEALTH DEA	AND I	MENTAL HYGIENI REG. NO.	7	5	187 un	ty
. DECEDENT'S NAME (First,	Middle, Lest) CECEL	TA	VANDEF	RSI TO	CF.				2. DATE OF DEATH DAY AND DAY 28.		YEAR	3. TIME OF 1:20	
			8. AGE (In yrs. lest		(ay) IF UNDER 1 YEAR IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year) Sept. 4, 19	Countr	RTHPLACE (State or Foreign		
Deaton Spec	cialty	The second of	& Home			Baltimore 9e. COUNTY (							
oo. STATE Maryland	Anne	Arundel			Y, TOWN O					10d. INSIDI	1?		
406 Morris		101. ZIP CODE 21060-0476					10g. CITIZEN OF WHAT COUNTRY?						

FUNERAL 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 YES 2 YNO Specify 3 Wildowed 4 Divorced Specify White ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Unknown Unknown Unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Charles William Vanderslice Sarah Mariah Bowie 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number/City or Town, State, Zip Code) Alice Van Dam 13915 Valley View Ave, La Miranda, CA 90638 (Niece) 20a, METHOD OF DISPOSITION
1 🙀 Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Congressional Cemetery 4 Donation 8 Other (Specify) 6 - 1Washington, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 23./PARX I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximats ahock, or heart failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition Myocardial Infarction resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular disease Sequentially list conditions. If any, leading to immediate cause. Enter UNDERLYING Hypertension CAUSE (Disesse or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Insulin dependent Diabetes Mellitus PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 X NO OF DEATH? 1 TES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4X3 Nursing Home 5 🗆 Residence 8 🗆 Other (Specify) 1 TES 2 X NO 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

28s. DATE OF INJURY (Month, Day, Year) 1 X Netural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

29a. CERTIFIER 1 [X CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and m

6. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIONED (Month, Day, Ybar)
FLORIOD SOME S'WD	D45148	May 28, 1995

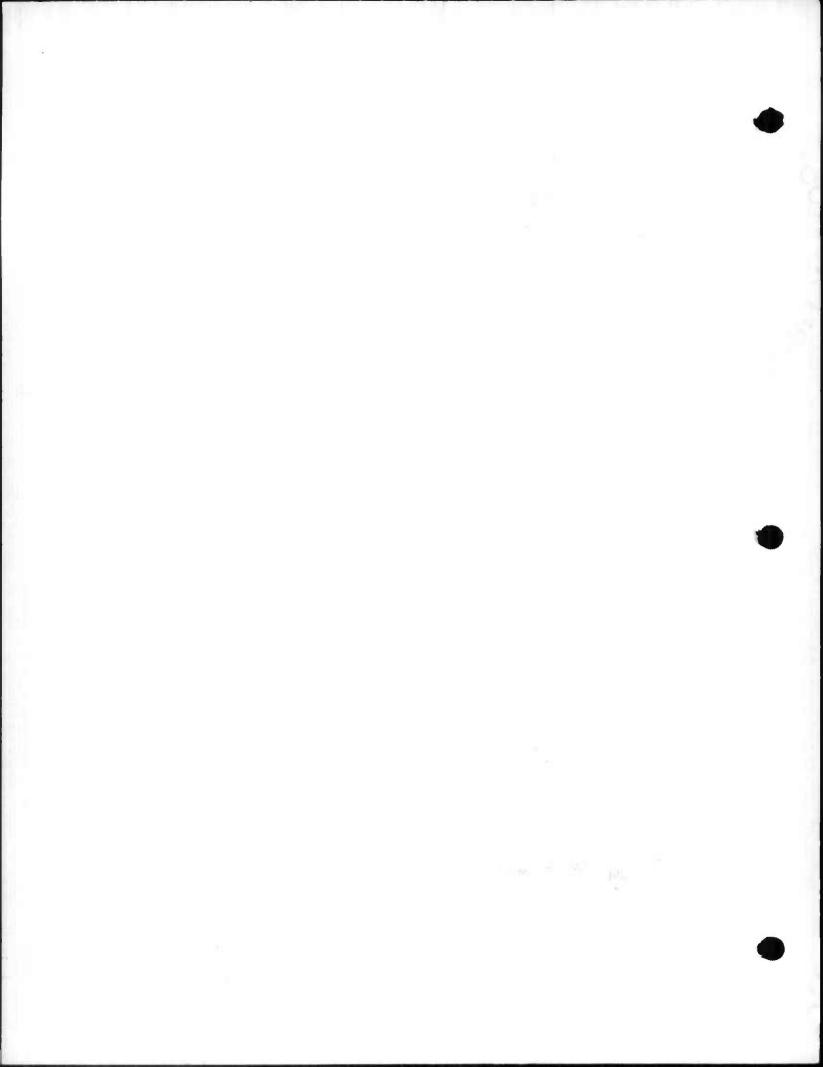
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

Ricardo Osorno, M.	D.	 South	Charles	St,	Baltimore,	MD	21230
1. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE						

MAY 31 1995 Julia Davelson Randall

8 Could not be

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)



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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

020 physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER  388-22-7658  90. FACILITY NAME (If not institution, give street and Manor Care—Bethesda RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  Maryland  Montgom  10a. STREET AND NUMBER  3801 Saul Road  11. MARITAL STATUS  12. We Follow Follows Follow	M 2   F   89  I number)  Cry  AS DECEDENT EVER IN U.S. ARI PRCES? 1   YES 2   N	t birthdey) YRS.  9b. CITY, TO Chev  10c. CITY, TOWN OR Kensing	OWN OR LOCATION OF DI	7. DATE OF BIRTH (Month, Day, War) Dec. 19, EATH	995  1905  9e. COUNTY OF D  Montgon  10g. CITIZEN OF V  United  or No. 14. RACE	DEATH  10-CENT  10-CE					
21215-0	COMPLETED BY	15. DECEDENT'S EDUCATION (Specify only highest grade complete	ed) (Gi life. Dir	CEDENT'S USUAL OCCI ve kind of work done dur Do NOT use retired.) Pector of Ident Activ	vities	National	BINESS/INDUSTRY ASSOCIA Ty Princi	hite tion of					
MARYLAND retained by the hospita 5 should be detached notified at once.	w	Elmer Van Pool  190. INFORMANT'S NAME (Type/Print)	191	o. MAILING ADDRESS (S	Effie	Smart							
May be		SUSAN VAN POOL  20a. METHOD OF DISPOSITION  1   Burlel X/X Cremetion 3   Removal fro  4   Donation 5   Other (Specify)	m State 20b, PLACEA cametery, crer	2707 Adams Mill Road,  20b. PLACE AND DATE OF DISPOSITION (Name of campliary, crematory or other place)			, NW, Washington, DC 20009  DATE 20c. LOCATION — City or Town, State						
Lam bruer		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	P. Chesa		matory ME AND ADDRESS OF FA P Funeral S Gist Avenu	Services, F	P. A.	Maryland					
co. BOX 68760  Retificate be executed within 24 hours after of fings physician and competelly filled into the training cremation, or removal.  other traumatic event, the medical as	RTIFICATION	23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on each lina.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Biventricular Congestive Heart Failure  DUE TO (OR AS A CONSEQUENCE OF):  Atherosclerotic Heart Disease  DUE TO (DR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
L RECORDS, P (aw requires that the death as been signed by the attentegt, of Health and Mental H 23 shows any Injury, or	IN: MEDICAL CE	PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.  Peripheral Vascular Disease; Chronic Obstructive  Pulmonary Disease  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN   244. WAS AN AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 X NO  25. WAS CASE REFERRED TO MEDICAL  26. PLACE OF DEATH (Check only one)											
TSTON OF UTENDING PHYSICI STOR: After this cer after death with the 28 is marked, o	ву РНУ	1 YES 2 NO 1 in in in in in in in in in in in in in	PITAL: patient 2 ER/Outpetient 3  Be. DATE OF INJURY (Month, Day, Year)  Be. PLACE OF INJURY — At horbuilding, atc. (Specify)	28b. TIME OF 18b. INJURY M	g Home 5 Residence c. INJURY AT WORK? I YES 2 NO office	8 Other (Specify)  28d. DESCRIBE HOW IN  281. LOCATION (Street e. City or Town, State)		loute Number,					
SPITAL OR A NERAL DIREC Thin 72 hours NT: tf Item	COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the						) end manner se stated.					
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 h	TO BE C	29b. SUNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO COMP	LTC CAUSE OF DEATH (ITEM	1 27) (Supp. Dulest)	D355	ABER	May 26	(Month, Day, Year)					
		Susan Miller, M. D. 31. DATE FILED (Month, Day, Year)		nsin Avenu	ue, Chevy C	Chase, MD 2	0815						

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31. DATE FILED (Month, Day, Year)

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		1 - FOR REGISTRAR	STATE OF I	MARYLAND C		RTMENT				MENT	AL HYGIEN REG. NO.	E		
		1. DECEOENT'S NAME (First, Middle, Last)  Jessie	Elizabet	h Va	nche	erie				MON		1995	YEAR	8:00A
0		4. SOCIAL SECURITY NUMBER 212-05-0313	5. SEX	6. AGE (in yrs. ia:	ol birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	7. DATI	E OF BIRTN oth, Day, Year)		8. BIRTNPI Country)	ACE (State or Foreign
pinous		Se. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN	OR LOCATI	ON OF DE	07-15-1903   sc. COUNTY OF			TY OF DEA	MD
1, 2, 3 s	ECTOR	425 N. Union	Avenue		Havre de Grace					e		Harfo		
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permit.		104. STREET AND NUMBER					-	. ZIP COD		10g. CITIZEN C				X YES 2 NO
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215-0020 attending physician, ise as the burlal-transit	BY FU	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Olvorced	FORCES?	NT EVER IN U.S. AF I YES 2 🔀 MAR OR DATES			f yee, sp	ENDENT Code 2 2 NO	m, Mexica	en, Puerto Ricen, etc.)				- American Indian, White, etc. White
21 Do u	LETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 6	(G	Ive kind of Do NOT u		turing mo	st of working	ng	16	b. KIND OF BUS	BINESS/IND	USTRY	Mile
AND 2 the hospital detached to once.	COMPL	11					Homemaker			r				
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retained 5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street e	nd Number	or Rural I	I Route Number, City or Town, State, Zip Code)				
be age	-	206. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of 200. PLACE AND DATE OF DISPOSITION DATE OF 200. PLACE AND DATE OF DISPOSITION DATE OF 200. PLACE AND DATE OF 200.									race			
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of within 24 hours after completely filled in by the it, cremation, or remove event, the medical		anock, or neart reliure. Liet only one ceuse on each line.										Approximata interval Between Onset and Death 5		
O. BOX 68 certificate be execute fing physician and or ygiene prior to buria other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									15 yrs			
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L RECORDS, law requires that the deal is been signed by the att ept. of Health and Menta 23 shows any Injury,	MEDICAL	PART II. Other aignificent condition								_	24s. WAS AN PERFOR	MED?	CO	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO
	Ž	DID TOBACCO USE CONTI	RIBUTE TO CA				-	LUNC	ERTAIN	1 🗆				
E 88 F	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 YOU	HOSPITAL:			OTHER 4 Nursi	:	offee	aldence	6 🗆 Oth	er (Specify)			
HYSICIA this certi with the	£	27. MANNER OF DEATH	26e. DATE OF (Month, D		26b. TIM		26c. INJU	JRY AT			SCRIBE NOW IN	JURY OCC	URED	
DING PHYS After this death with	ВУ	1 Netural 5 Pending 2 Accident Investigation	(Month, D	esy, rousy	1143	M	1 Y	ES 2	NO					
TTENDII	8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm, :	itraet, fecto	ry, office	)			CATION (Street e. or Yown, State)	nd Number o	or Rural Rou	te Number,
TAL OR TAL DIRI 72 hour	COMPLET	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE												
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: It i	8			amination end/or i	rrvestigatio	n, in my op	oinion, de	eath occur	ed at the	time, dat	e and plece, end	due to the	ceuse(e) e	nd manner as stated.
TO THE HOSP TO THE FUNE De filed within	TO BE	29b. SIGNATURE AND TULL OF CERTIFIER	-W					29c. LICE	27	BER	4			onth, Day, Year) , 1995
	-	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAD	SE OF DEATH (ITE	4 27) (Type,	Print)								

Louis Silverstein, M.D., P. O. Box 8, Havre de Grace, MD 21078, 410-939-5843

32. REGISTRAR'S SIGNATURE Juli Shudson Rashell

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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30. NAME AND

29b. SIGNATURE AND TITLE OF CERTIFIER

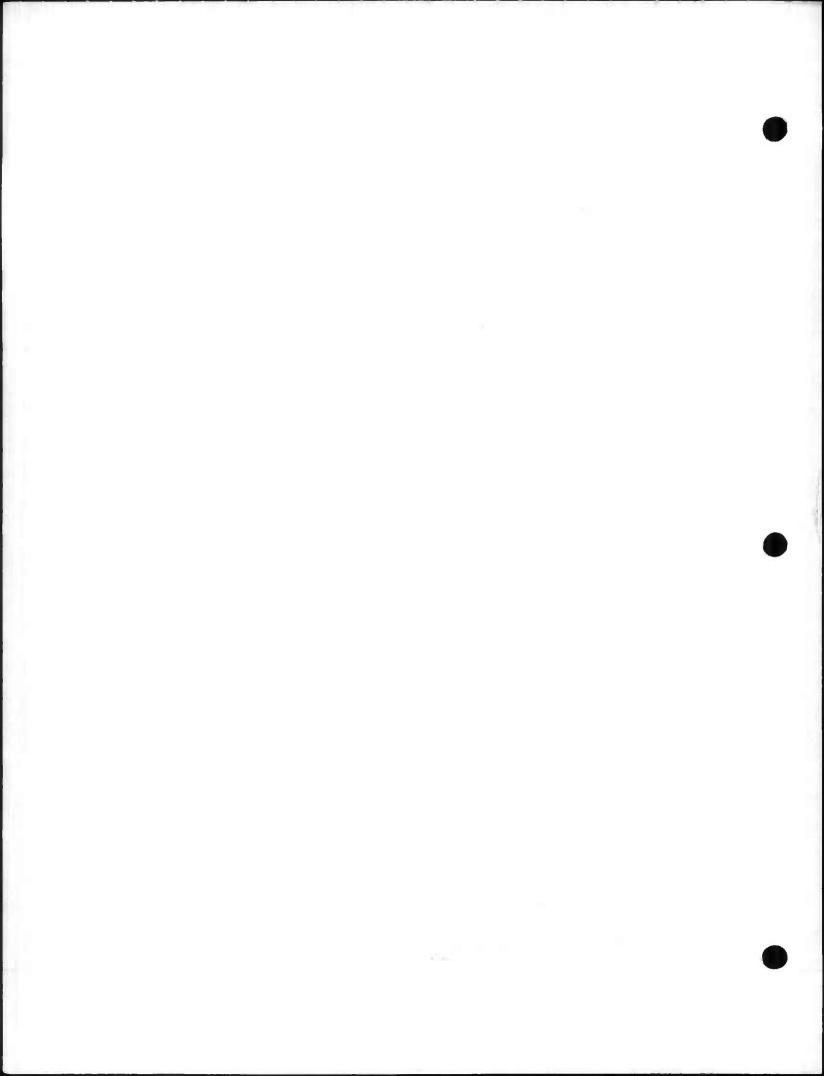
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31. DATE FILEO (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH Venerable 1995 135 A )gry JUNG 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 219 84 265 1 X M 2 F YRS. MARCH 4 1963 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR 930 PRESIDENT RESIDENCE OF DECEDEN ST.APT. ANNAPOLIS ANNE ARUNDEL 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEI 1 XYES 2 NO ANNAPOLIS 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? APT. 930 PRESIDENT ST USA 21403 В 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 YO Specify: 14. RACE — American Indian, Black, White, etc. 1 Nover Married 2 Married BY 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 18e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ritary/Secondary (0-12) College (1-4 or 5+) 11th BOAT FINISHER ANNAPOLIS HARBOR YACHT YARD 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JAMES VENERABLE, JR. VIOLA SMITH BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 VIOLA VENERABLE 930 PRESIDENT ST. B 2 ANNAPOLIS, MD. 21403 APT. 20a. METHOD OF DISPOSITION
1 Q-Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State ANNAPOLIS MEM. GARDENS 6/9/95 ANNAPOLIS, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
REESE & SONS MORTUARY, P.A. D. Ste Larry 821 WEST ST. ANNAPOLIS, MD. 21401 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heert failure. List only one cause on each line. Interval Betwe **IMMEDIATE CAUSE (Final Onset and Death** disease or condition neumonia 3WKS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? Discouse AMILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? ADDS Complex 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 270 NO 4 Nursi ng Home 5 Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 | Homicide 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24b. WERE AUTOPSY FINDINGS 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 6/7/95 lerbaum 3856 AOORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) Rd 134 oversulle West Rhen My CUI 32. REGISTRAR'S SIGNATURE
Julia Shuulaar Randall OHMH-16 Rev 1/89

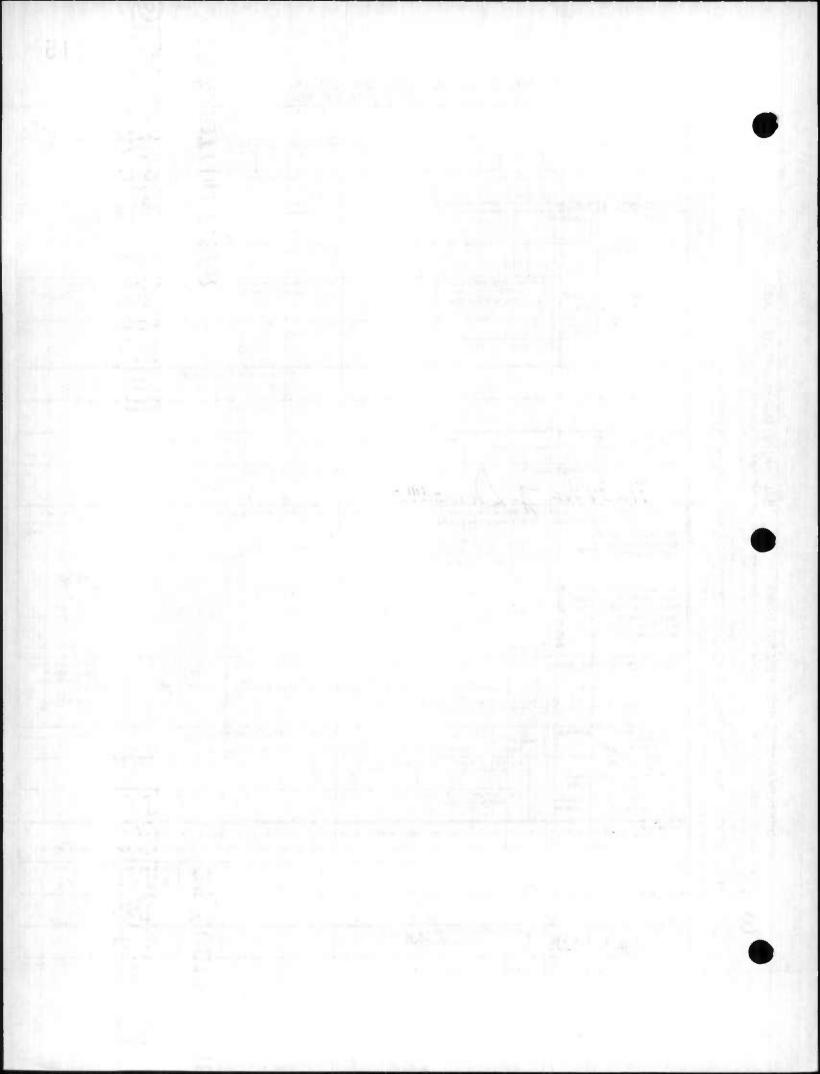


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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	Account on personal property of the state of
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30	REGISTRAR  CERTIFICATE OF DEATH  1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  STAR 3. TIME OF DE									F DEATH		
	Joseph R. Vesp					_		pagy:	31,10	195 10	31/	
	4. SOCIAL SECURITY NUMBER 214-34-1257	5. SEX	6. AGE (In yra. I	-	ONTHE DAY	-	R 24 HRS.	Dec 3, 19	24	B. BIRTHPLACE (Sta Country)	te or Fore	
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5	RESIDENCE OF DECEDENT	O HOLL			TIGOL	- LUCAT			1	LDINGGK		
рівестоя	10a. STATE 10b. COUN		erick Wal			TY, TOWN OR LOCATION				10d. INSIC		
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FUNERAL	220 Burlington Avenue				10f. ZIP CODE 10g				US.	ZEN OF WHAT COUN A	ITRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell yes, specify Cuben, Mexican, Puerto Rican, etc.) 1  YES 2  SeO			14. RACE — American Indian, Black, White, etc. Specify: White				
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COMPLET	12		I	Former Owner Operator			r Service Station					
CO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Melden							
BE (	Rev. Arthur	Vespa						Chiappell				
2	19a. INFORMANT'S NAME (Type/Print)							Route Number, City or To			03	
	Linda Cessna							e; Walkersville, MD 21793				
	20a. METNOD OF DISPOSITION  1 Surial 2 Cremetton 3 Re 4 Donation 5 Other (Specify)	moval from State	al from State 20b. PLACE AND DATE:							City or Town, Stata land, MD	21	
	22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
,	ahock, or heart failure. Les only one cause on each lina.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):											
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. Haltride Scotled C.V.I.  DUE TO IOR AS A CONSEQUENCE OF):  C. DUE TO IOR AS A CONSEQUENCE OF):  DUE TO IOR AS A CONSEQUENCE OF):  d								4.			
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CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL				PLACE OF	DEATH (C	neck only one)				
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ву рн	27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigation	on			ME OF JURY AT WORK?  M 1 YES 2 NO			28d. DESCRIBE NOW INJURY OCCURED				
ED	3 Suicide 8 Could not b 4 Nomicide determined					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
	29e, CERTIFIER	SICIAN: To the heet	of my knowledge.			nin sind stan	a and du	to the cause(s) and mi	nner as stat	ed,		
COMPLET	(Check only							time, data and place, a			er aa s	

1900 Rosemont Ave. Frederick, MD 21702

Bernard O. Tho 31. DATE FILED (Morth, Day, Year JUN 0 2 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760

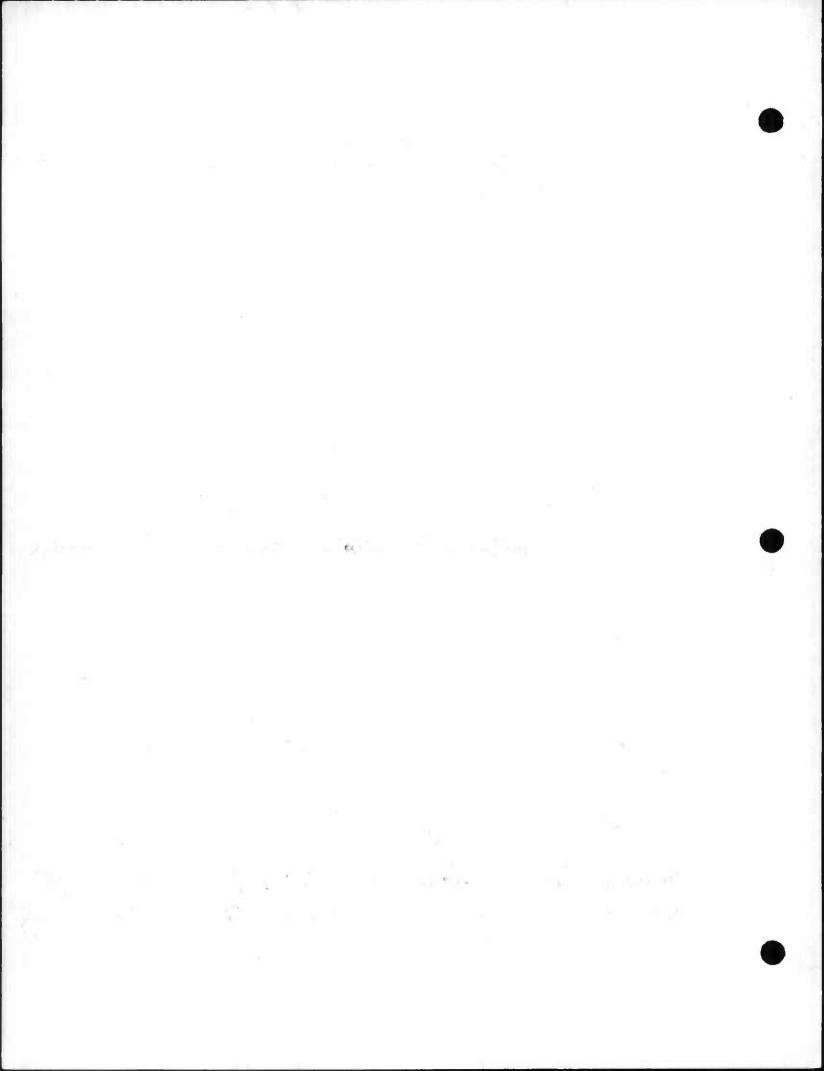
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pres 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the times of should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the median examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	IEALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	MARGARET L. WILL	JIAMS					1995	10:15 AM		
TOR	4. SOCIAL SECURITY NUMBER		20	FUNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Coun	HPLACE (State or Foreign		
	577-10-0924		OU YAS.			Aug. 17,	1914 Was	nington, D.C.		
	90. FACILITY NAME (If not institution, give a 3701 Internationa	Committee of the commit		Silver	Spring	EATH	Marylar			
EC	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT	10c, CITY.	TOWN OR LOCAT	ION			10d, INSIDE CITY			
BY FUNERAL DIRECTOR	Maryland Montg		ver Spr	ing		1 X YES 2 NO				
	3701 Internationa	315		20906		WHAT COUNTRY?				
	11. MARITAL STATUS 1  Never Married 2 Merried 3 Widowed 4 Divorced	U.S. ARMED 2 NO ES	If yes, spi	ENDENT OF HISPAN solfy Cuben, Mexice 2 NO Specify	IIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	Spec	RACE — American Indian, Black, White, etc. Specify: White			
TED	15. DECEDENT'S EDU (Specify only highest grade	Give kind of wo	rk done during mo-	ON st of working	16b. KIND OF BU	SINESS/INDUSTRY				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	ille. Do NOT use Sect	retary		U.S.	Governme	nt		
ő	17. FATHER'S NAME (First, Middle, Last)			-	16. MOTHER'S NAI	ME (First, Middle, Melden	Sumame)			
BE	Harry O. Mackin				0		Estella McCrea			
2	19a. INFORMANT'S NAME (Type/Print)  David Owen William					Houte Number, City or Tow		W4 00007		
						Street, Ar				
	30s, METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem	ioval from State 20b, P	ery, cremetory or other LINCO	DISPOSITION (Ne	me of	1		od, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC		L LINCO.					Funeral Home		
	Jude 1	my h_		11800	New Hamp	shire Ave	nue	andraz nome		
	23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. metastatic ovagian cancle months									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):									
AL (	PART II. Other aignificant condition	ne contributing to death but	not resulting in	the underlying	cause given in i	Part I. 24a. WAS AN		. WERE AUTOPSY FINDINGS		
5	PERFORMED?  1 YES 2 N							AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
							1 YES 2 NO			
Z	DID TOBACCO USE CONTI				UNCERTAIN	1 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:									
14S	1 YES 2 MO	1   Inpatient 2   ER/Outpati			5 Tesidence		Co. Co. et al. Desert			
	1 Natural 5 Pending (Month, Day, Year) NJURY WORK?									
D BY	2 Accident  3 Suicide 6 Could not be  28e. PLACE OF INJURY — At home, farm, street, factory, office  28f. LOCATION (Street and Number or Rural Route N							Route Number,		
TED	4 Homicide determined building, atc. (Specify)									
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner as stated.									
- 11	29b. SIGNATURE AND TITLE OF CENTIFIED				29c. LICENSE NUM					
BE	martha Sp	encer Xa	avedr		D41	172	29d. DATE SIGNED	06-96		
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEATH			- 11	1-3	2-			
		RACER	Saa	vedR	A .370	Internat	ional De	Silver Sprin		
	31. DATE FILED (Month, Day, Year)  MAY 3 0 100	5 July Office	URE Rardall		,					



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

4. SOCIAL SECURITY NUMBER

Ruth Hope Williams

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<b>BOX 687</b>	
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HOURS 144-36-6458 1 M 2 X F YRS. 51 Oct. 14, 1943 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION D.C. N/A Washington 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 7436 - 9th Street N.W. Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 20012 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 4 Registered Nurse Medical 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Harry A. Payne, Sr. 7 Ruth Edwards BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Ernest Y. Williams, Jr. 7436 - 9th St.N.W., Washington, D.C. 20012 METHOD OF DISPOSITION 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must Buriel 2 Cremation 3 Removal from State funeral director, Rock Creek Cemetery 4 Donation 5 Other (Specify) 5/31/95 Washington, D.C. 21. SIGNATURE OF PUNETAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY hours after death. McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, the 22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by ahock, or heart fallure. Liet only one ceuse on each line. 6 **IMMEDIATE CAUSE (Fine)** cremation. the disease or condition Stria Nunocytogens meningitis + sepi completely event, resulting in death) executed within bunal. Ne DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION this certificate has been signed by the attending physician and with the State Dept. of Health and Mental Hygiene prior to bun Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING 2 requires that the death certificate CAUSE (Disease or injury other DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury. PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. WAS AN AUTOPSY PERFORMED? MEDICAL эпу respiratory distess YES 2 NO shows ; lenal faillire DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 🗆 PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The Item OTHER: 1 YES 2 NO DR ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) the 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, Netural TO THE HOSPITAL DR ATTENDING PH TO THE FUNERAL DIRECTOR: After the De filed within 72 hours after death w IMPORTANT: If Item 28 is mark 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fentin tosonste 31. DATE FILED (Month, Day, Year) Jalin Studior Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

6. AGE (In yrs. last birthday)

2. DATE OF DEATH

May 25,

7. DATE OF BIRTH

1995

95 18717

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

**Black** 

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2

Onset and Death

rent

OH

1X YES 2 NO

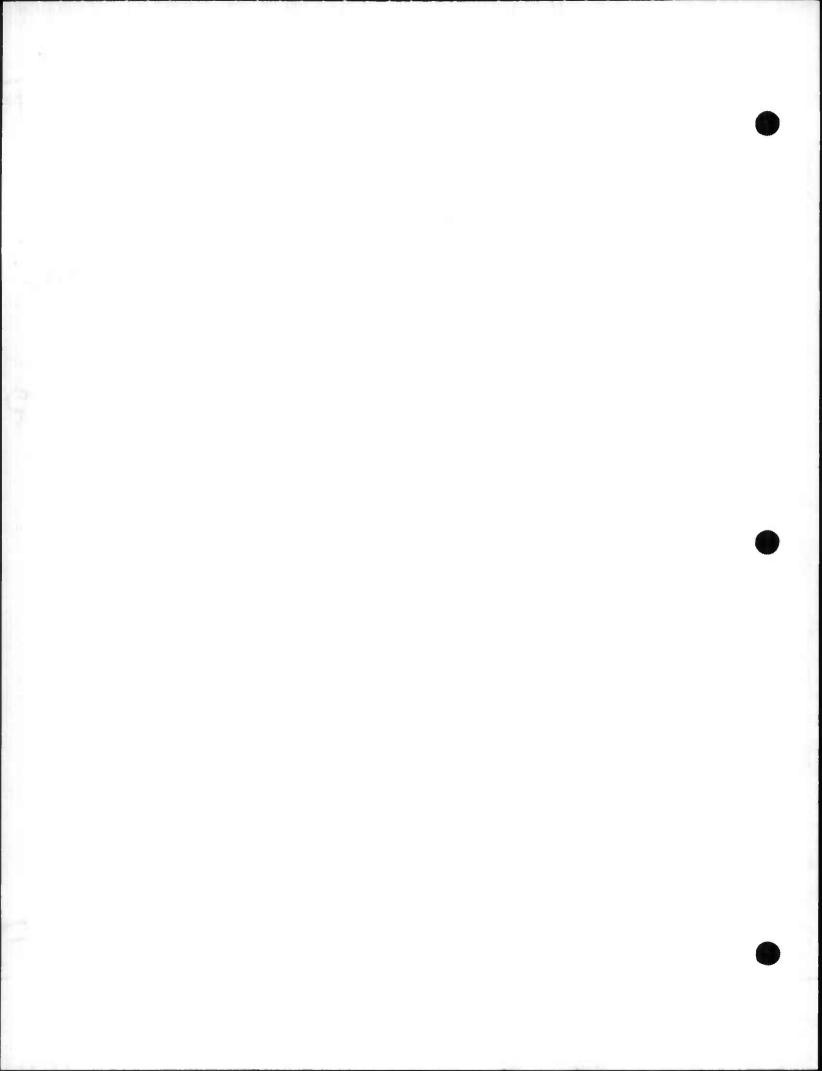
6. BIRTHPLACE (State or Foreign

New Jersey

1:23 P

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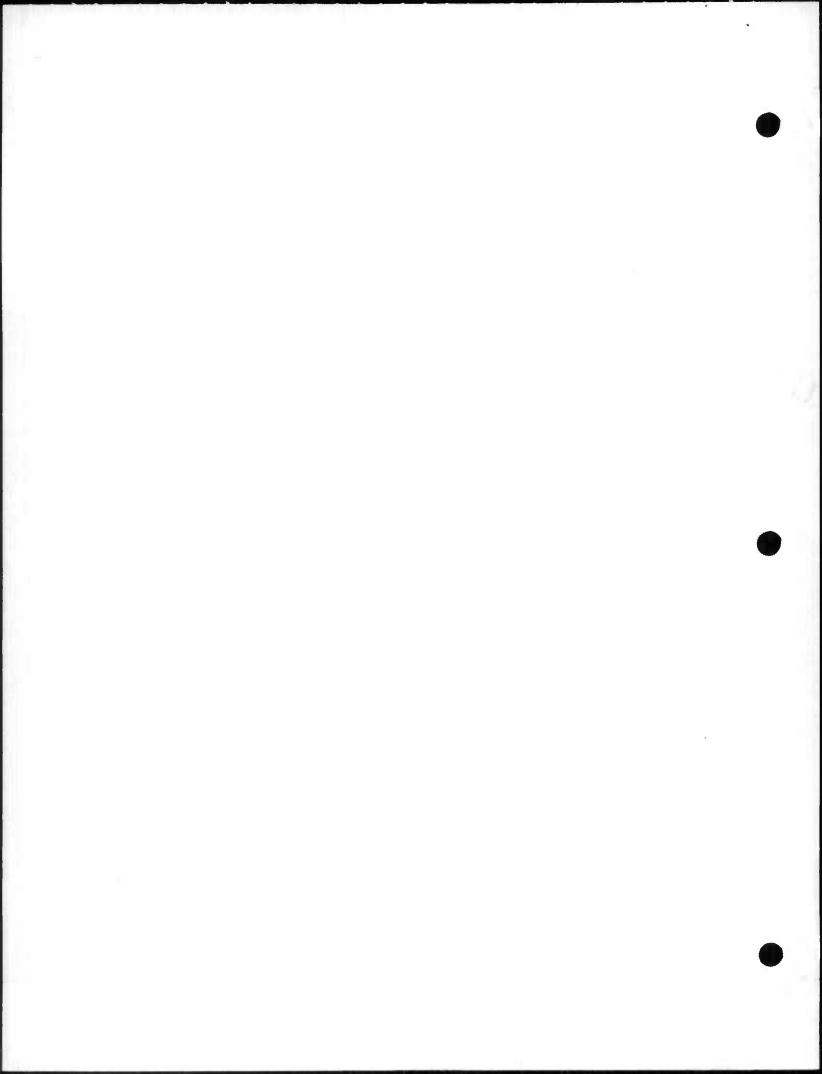
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNE FALL DIRECTORS After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be med writin 72 hours aren dean with the State Dept. or readin and wental hydrer prior to bunal, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Jean Maca	donald W	alsh				995	1:20 P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Dev. Year)	8. Briti	BIRTHPLACE (State or Foreign Country)		
	212-64-3740		6 YRS.	MONTHS DAYS	HOURS MIN,	July 31,1	918 Pen	nsylvania		
~	Sa. FACILITY NAME (If not institution, give str	reet and number)		9b. CITY, TOWN O	R LOCATION OF D	EATH	9c. COUNTY OF	DEATH		
ğ	Holy Cross Hospit	al		Silver	Spring		Montgom	ery		
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										
										AL
FUNERAL	9505 Riley Road				20910		U.S.A			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Yes		CE — American Indian, ck, White, etc.		
ВУ	1 Never Married 2 Married  3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Specif	in, Puerto Rican, etc.) y:		city:		
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S U	101141 0001101710		T		White		
	(Specify only highest grade of Elementary/Secondary (0-12)	completed)	(Give kind of we	ork done during mos retired.)	st of working	166. KIND OF BUS	SINESS/INDUSTRY			
PL	Exercise visually (0-12)	College (1-4 or 5+)	Homema	ker		Own 1	Home			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		помена	RC I	16. MOTHER'S NA	ME (First, Middle, Maiden				
BE (	Frank Macdonal	-d			Agnes	Fitzpat	rick			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street ar		Route Number, City or Tow		20874		
-	Michael F. Walsh		19254	Misty Me	eadow Te	rrace Germ				
	20a, METHOD OF DISPOSITION 1   ☐ Burial 2 ☐ Cremation 3 ☐ Ramo	val from State 20b.	PLACE AND DATE OF	F DISPOSITION (Name place)			CATION — City or 1			
	4 Donation 8 Other (Specify)		John s			/31/95 For	est Glen	,Maryland		
	21. SIGNATURE OF FUNCIAL SERVICE LICE	INSEE			D ADDRESS OF FA	ciuty 11ins Fune:	ral Home	. Inc.		
- 9	noberl	E. Kam	Jey	500 Ut	niversit	v Blvd.W.	Sil.Spr			
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused lat only one cause on ea	the death. Do no	ot enter the mod	le of dying, suc	h aa cardiac or respi	ratory arrest,	Approximata Interval Batween		
	IMMEDIATE CAUSE (Final disease or condition	0 1 -						Onset and Death		
1	resulting in death)	Kenal Fo	rilure					12 hrs		
		DUE TO (OR AS A	2.00							
ON I	Sequentially list conditions,	Mesenteri DUE TO FOR AS A ARTERIOS	CONSEQUENCE OF	erim	MUSUTTI	clency		zyears		
SAT	If any, leading to immediate cause. Enter UNDERLYING	ARTERIOS	LEROTIL	VASCU	WAR D	SEASE		15 Years		
Ĕ	CAUSE (Disease or injury that initiated events		CONSEQUENCE OF)							
CERTIFICATION	resulting in death) LAST									
AL C	PART II. Other aignificant conditions	contributing to death bu	It not resulting in	the underlying	Cause given in	Part I. 24s. WAS AN	AUTOBEY 24	b. WERE AUTOPSY FINDINGS		
3	Myeloprolif	erative di	sease		vadoo given in	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
밀	J (2.01)	The Man	OCC			1 YES 2	NO	OF DEATH?		
≥ ;	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	NO 🗆	UNCERTAIN			1 TES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH		OTTOLIVIAN	, 0				
SIC	1 TES 2 NO	HOSPITAL:		OTHER: 4 - Nursing Home	5 Rasidenca	6 Other (Specify)				
E	27. MANNER OF DEATN	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJU	RY AT	28d. DESCRIBE NOW II	NJURY OCCURED			
ВУ	1 Natural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ES 2 NO					
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY - building, atc. (Specif	— At home, farm, at	reet, factory, offica		261. LOCATION (Street a City or Yown, State)	and Number or Rural	Route Number,		
COMPLETED										
AP.	29a. CERTIFIER (Check only one)									
Ö	2 MEDICAL EXAMINER	On the basis of exemination	and/or investigation	, in my opinion, de	ath occured at the	time, data and place, and	d dua to the cause	s) and manner as stated.		
BE	286. SIGNATURE AND TITLE BY CENTIFIER	MA			29c. LICENSE NUN	IBER	29d. DATE SIGNE	(Month, Day, Year)		
0	yeary our	110			D2115	3	▶ 5-27			
	30 HAME AND ADDRESS OF PERSON WHO		TN (ITEM 27) (Type, I	Print)	3 - 2 - 1.	re Ave	SILVER	SPRING, Md.		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		vew The	INSPIN	12 MVC	2090	4		
	MAY 31 1995	1	- O							
	<u>יייהו 11 1995</u>	Juli Savelyan	Contatt							



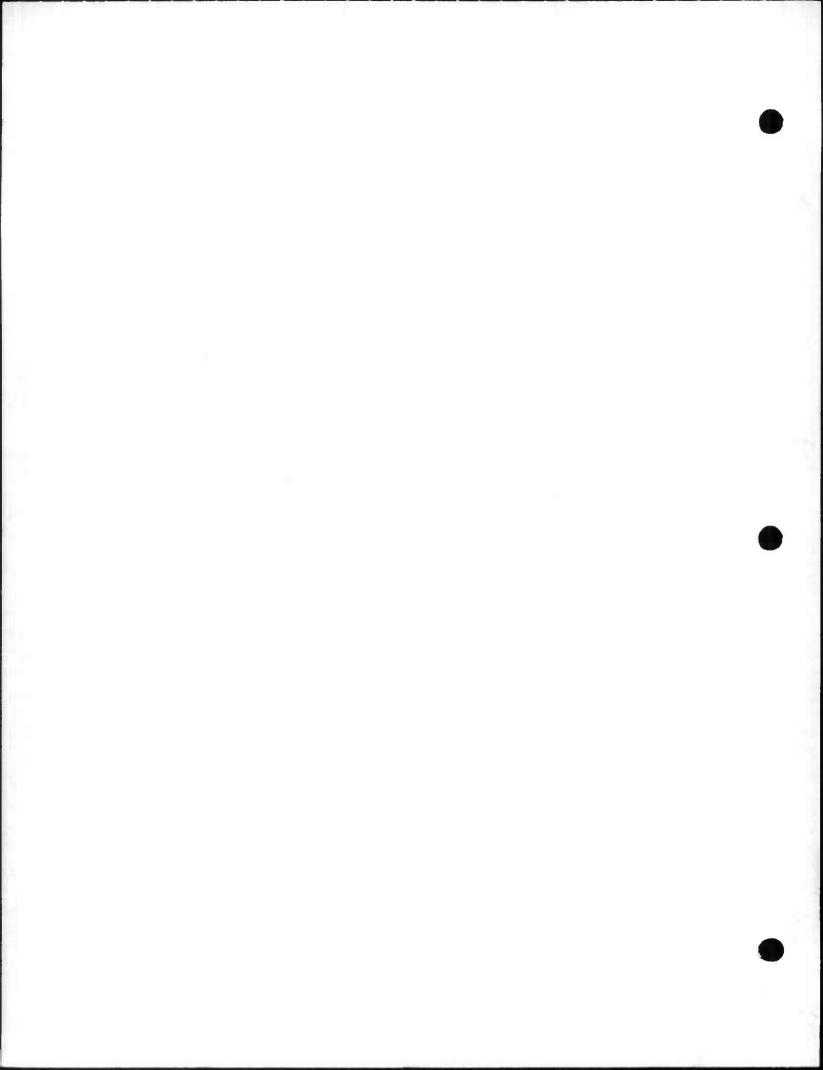
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. From: after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			IME OF DE	ATH		
	Frances	Wolk				May 25	1995	YEAR 10	:30	A. M		
			n yrs. lest birthday)	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign							
Ü	215–46–3648  9e. FACILITY NAME (if not institution, give stree	1 M 2 F		ashin	2	DC						
DIRECTOR	Potomac Valley Nur			Rockvil	DR LOCATION OF D	EATH		gomer				
3EC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
L DI	MD Montgomery Rockville											
FUNERAL	101. ZIF CODE 109, CITIZEN OF 1											
NE NE		Y ROAU 12. WAS DECEDENT EVER IN	U.S. ARMED	13 WAS DEC	20000	NIC ORIGIN? (Specify Ye	US	4. RACE — A		dia		
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Maxic	an, Puerto Rican, etc.)	a or No —   14	Black, Whi	ita, atc.	men,		
Э ВҮ	3 X Widowed 4 Divorced	ii res, are minor on		I TES	2 NO Speci	ny:		Specify:	hite			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	rion impleted)	(Give kind of v	USUAL OCCUPATION	ON asl of working	16b. KIND OF BU	ISINESS/INDUS	TRY				
Z.		College (1-4 or 5+)	ille. Do NOT us			***	! -					
ME	12 17. FATHER'S NAME (First, Middle, Last)		Housew	ire		House						
	Louis Epstein					AME (First, Middle, Melder a Rabinowi	1000000					
8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Tox		orie)				
5	Natalie Coran			Cushmar		Rockville						
	20a. METHOD OF DISPOSITION 1 [XBurial 2 ] Cremetion 3 ] Remove		PLACE AND DATE O	OF DISPOSITION (No	ame of	DATE 20c. LC	OCATION — CIN	y or Town, S	ista			
	4 Donation 6 Other (Specify)	Bna		1 Congre	egation	5-26 0xo	n Hill	MD				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /		Edward	Sage1	Funeral Di	rectio	n				
	all	d				e Pike Ro			20852	2		
	23. PART I. Enter the diseases, or cor shock, or heart feilure. Lis	mplicetions that caused	the death. Do n	ot enter the mo	de of dying, suc	ch as cardiac or resp	iratory arres	it,	Approxi			
- 1					,			į	Onset sr			
	disease or condition resulting in death)	Caron	014	ART	ERY	Distast			400	115		
_	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Coronary Anteny Dislave  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7:		0,00			7-09	73		
3	cause. Enter UNDERLYING CAUSE (Disease or injury											
E	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF	7):								
빙	d											
AL	PART II. Other aignificent conditions	contributing to death bu	t not resulting i	n the underlying	g cause given in	Part i. 24a. WAS AM			E AUTOPSY ABLE PRIO			
DIC	Emphy st	ma				1 YES :		COMI	PLETION DE			
MEDIC	Dement	d				_			YES 2	No		
Z	DID TOBACCO USE CONTRI			S P NO [	] UNCERTAI	N 🗆	102					
PHYSICIAN:		OSPITAL:	6. PLACE OF DEAT	OTHER:								
ΙΥS	1 YES 2 AND 1	☐ Inpatient 2 ☐ ER/Outpa		4 D Hursing Hom		8 Other (Specify)						
	1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ	URY WO	RK?	28d. DESCRIBE HOW	INJURY OCCUP	#ED				
BY	2 Accident Investigation	28s. PLACE OF INJURY	- Al home farm a		/ES 2 NO	201 LOCATION (Comp.)	and Mumber or	Provide Device 1	V			
COMPLETED	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State)											
3	290. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my knowle	dae death accurre	ad at the time date	and plans and due	to the second of the second	220.0		-			
M	298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.  (Check only one)  1 (CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.											
	29b. SIGNATURE AND TITLE OF CERTIFIER				29 LICENSE NUI			IGNED (Mont				
B	K. albert	21).			231	319	15.	-25	-9	-		
2	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	0 1	31/		-	-			
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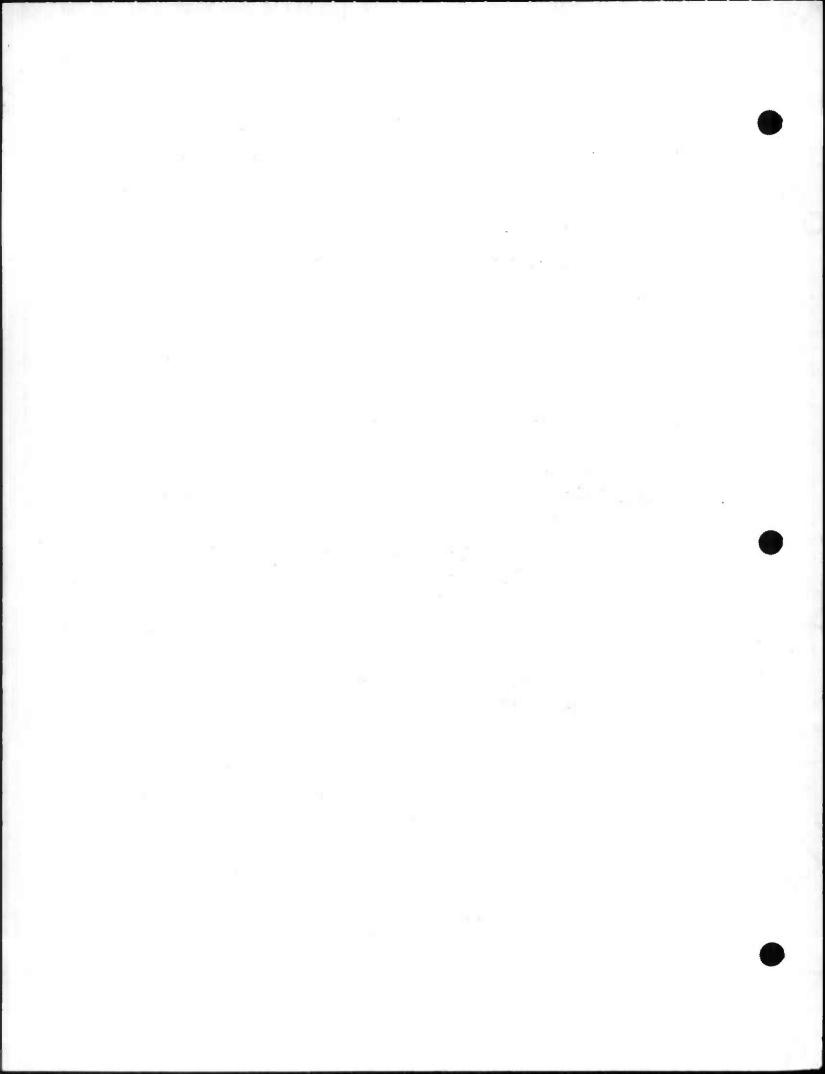
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	MENT OF H	EALTH AN	D MENT	AL HYGIEN	E				
	1. DECEDENT'S NAME (Figt, Middle, Lest)	e	11511	ims		2. DA	TE OF DEATH DA	V Y	EAR	3. TIME OF DEATH  2:15 P. M		
								7. DATE OF BIRTH 8. BIRTHI				
	041–18–5243  9a. FACILITY NAME (If not institution, give stre-	1 🗆 M 2 🔀 F 91 YRS. MONTHS DAYS H					March 4 1904 Hungary					
Œ		of and number)		9b. CITY, TOWN C		F DEATH		9c. COUNTY				
5	Suburban Hospital			Bethe	sua			Monto	Jone	ry		
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION ROCKVILLE											
FUNERAL	10e. STREET AND NUMBER				. ZIP CODE			10g. CITIZEI	N OF WI	HAT COUNTRY?		
NER	1801 East Jefferso	n Street			20852			USA				
BY FUI	1 Never Married 2 Married	12. WAS DECEDENT EVER IN U. FORCES? 1 YES :	2 NO	If yes, spi	ENDENT OF HIS ecify Cuban, Ma 2-2 NO S	exican, Puer	GIN? (Specify Yes to Ricen, etc.)	or No 14	. RACE - Black, Specify	— American Indian, White, stc.		
	3 Widowed 4 Divorced									white		
COMPLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co	ompleted)		JSUAL OCCUPATION Ork done during mo-		1	66. KIND OF BUS	INESS/INDUS	TRY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 6+)	Librar	<i>'</i>			Govern	ment.				
Ö	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S	S NAME (Firs	t, Middle, Malden					
BE C	Eli Klominsky				Rach	ael L	apidus					
TO B	19s. INFORMANT'S NAME (Type/Print)			ADDRESS (Street s				n, State, Zip Co	ide)			
-	Louis H. Kornhause	er	15310	Pine Or	chard 1	Drive	Silve	r Spri	ng	MD 20906		
	20a. METHOD OF OISPOSITION  1 Burlel 2 Cremation Common	of from State cameter	ry, crematory or oth	F DISPOSITION (Na per place)		1		CATION — CITY		rn, Stata		
	4 ☐ Donation 5 ☐ Other (Speaky)		i Jacobs	Memorial	Park P ADDRESS OF	5-	30 New H	aven, C	T	-		
	181,131	***************************************		Edwar	d Sage:	l Fun	eral Di			m 20050		
	23. PART I. Enter the diseases, or cor	mplications that caused th	ne deeth. Do no	ot enter the mo	de of dylng,	auch as co	rdiec or respir	ratory arrea	<u>.e.</u> M	D 20852 Approximate		
	ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition reaulting in death)	CONVESTIVE	10.	Faily	re,					Interval Between Onset and Death 2 Weeks		
				:						10ug-		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	NSEDUENCE OF	1						Harley		
S	cause. Enter UNDERLYING CAUSE (Disease or Injury			V								
	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	INSEQUENCE OF	:								
5	d.,											
AL (	PART II. Other significant conditions	contributing to deeth but		the underlying	ceuse giver	In Part I.	24s. WAS AN		24b. V	WERE AUTOPSY FINDINGS		
200		do monocut		ullem	a		1 TYES 2	mED!		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME		Callure 1								TO YES 2 2 NO		
Ä	DID TOBACCO USE CONTRU				UNCERT	AIN 🗆						
PHYSICIAN: MEDIC		IOSPITAL:	PLACE OF DEATH	OTHER:								
TYS	1 YES 2 NO 1	28s. DATE OF INJURY	nt 3 DOA	OF 28c, INJI		- V						
	1 Miturel 5 Pending	(Month, Day, Year)	INJU	RY WO			ESCRIBE HOW IN	JUNY OCCUR	EO			
2   Accident 3   Suicide 4   Homicide  29a. CERTIFIER (Check only one) 2   MEDICAL EXAMINER: Dn the basis of sxamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a)									Rural Ro	ute Number,		
One) 2 MEDICAL EXAMINER: On the basis of sxamination and/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(a) and manner as a									and manner as stated.			
									Month, Day, Year)			
TO BE	wal use sol	mo			1/21	435	-	1 M	my !	26 1493		
Ĕ	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, )	APAIIA	Mille	(A	c 5,1	1000	21.40	Milyou		
	31. DATE FILED (MONTH), Day, Year)   Day, REGISTRAR'S SIGNATURE  MAY 31 1995   Will Day College   Da											



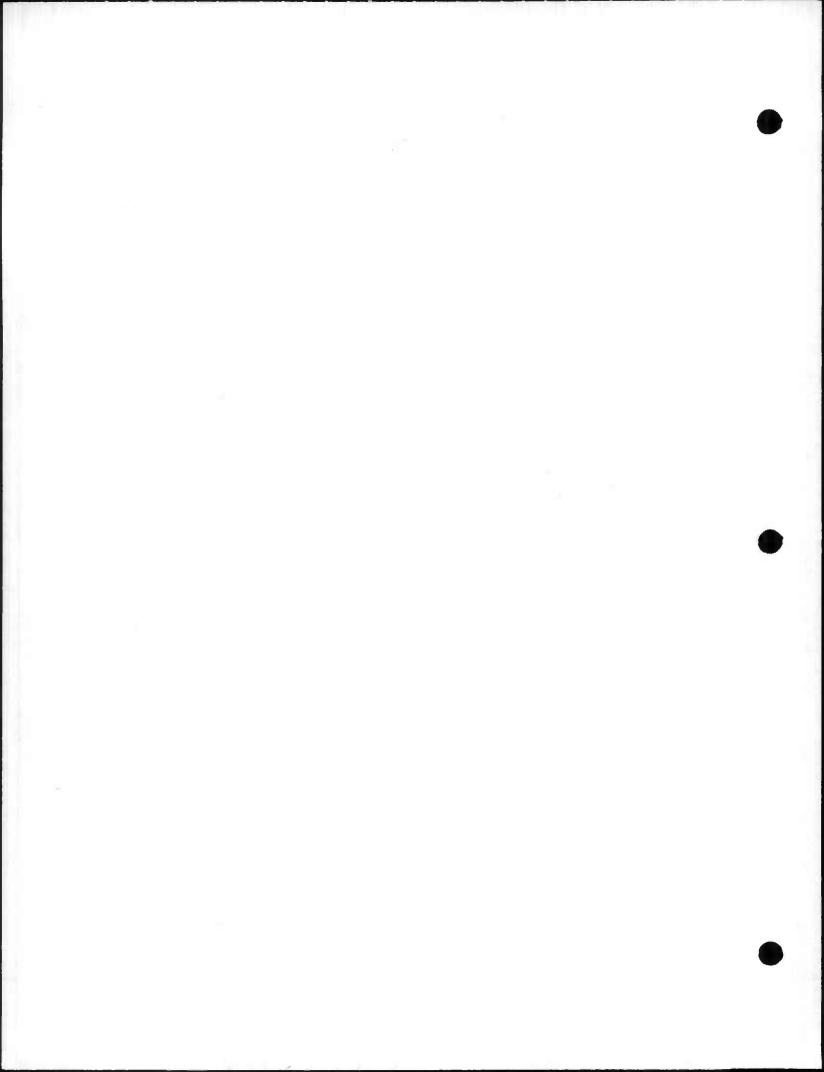
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BALTIMORE, MARYLAND 21215-0020	8
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	uted within 24 hours after death. Page 6 may be retained by the hospital or attending phys
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OS, P.O. BOX 68760	he death certificate be executed

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATH												3. TIME OF DEATH		
	Robert Wilson Ward, Sr.										May 29 1995 11:00 a				
	4. SOCIAL SECURITY NUME	23.00	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	7		R 24 HRS.		OF BIRTH		8. BIRTHE	PLACE (State or Foreign	
	213-03-1185	YRS.	MONTHS	DAYS	HOURS	MIN.		3, 19	10	Gaith	nersburg,MD				
~	Se. FACILITY NAME (If not in					9b. CITY	r, TOWN	OR LOCAT	ION OF D				INTY OF DE		
FUNERAL DIRECTOR	Wilson Heal		Gai	ther	sbu	rg			Mor	ntgome	ery				
EC	10a. STATE	10c. CIT	DC. CITY, TOWN OR LOCATION 10d. INSIDE (							10d. INSIDE CITY					
금	Maryland	Mont	gomery		Ga	ithe	rsbu	ırg						LIMITS?	
AL	10e. STREET AND NUMBER						101	. ZIP COC	E			10g. CIT		HAT COUNTRY?	
F	108 Russell	Avenu	e				2	087	7			Unit	ed St	tates	
E	11. MARITAL STATUS 1 Never Married 2 X	Mandad	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT	OF HISPAI	NIC ORIGI	Y? (Specify Yes			- American Indian, White, etc.	
BY	3 Widowed 4 Divo		IF YES, GIVE W						Specif				Specify	r:	
	15. DEC	EDENT'S EDUC	CATION	16a, DE	CEDENT'S	USUAL O	CCUPATIO	W		161	. KIND OF BU	DIMEGO /IM	DUCTOV	White	
COMPLETED	(Specify only Elementary/Secondary (0	y highest grade	College (1-4 or 5	(Gi	Do NOT us	work done	during mo	st of work	ing	100	C IGHO OF BO	31111237111	DOSTRI		
로	12				resti	gato	r			Fε	deral	Gove	rnmer	nt - GSA	
Ö	17. FATHER'S NAME (First, M	liddle, Last)						16. MOT	HER'S NA	ME (First,	Middle, Maiden	Sumame)			
BE (	Carson Ward							Can	rrie	Dark	у				
6	19a. INFORMANT'S NAME (7										ber, City or Tow				
	Mary Butts								e, Ga		rsburg				
	20a. METHOD OF DISPOSITI	n 3 🗆 Ramo	oval from State	20b. PLACE A cemetery, crea	ND DATE O	OF DISPOS	SITION (Na	me of	(101	OAT	E 20c. LO	CATION —	City or Tow	n, Stata	
	1 M Burlel 2   Cremation 3   Ramovel from State   Camelon, crematory or when place   Forest Oak Cemetery 6/2/95   Caithersburg,   Camelon, crematory or when place   Forest Oak Cemetery 6/2/95   Caithersburg,   Canelon - City or Town, Segmetery, crematory or when place   Forest Oak Cemetery 6/2/95   Caithersburg,   Caithersburg,   Canelon - City or Town, Segmetery, crematory or when place   Forest Oak Cemetery 6/2/95   Caithersburg,   Canelon - City or Town, Segmetery, crematory or when place   Forest Oak Cemetery 6/2/95   Caithersburg,   Caithersburg										, Maryland				
	. \	19	VI	)		1	0 Ea	st I	eer	Park	Drive	r une	ilal I	ione	
_		·C. 1	Juk			G	aith	erst	ourg.	MD	20877				
}	23. PART I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Batween														
	IMMEDIATE CAUSE (Finel											Onset and Death			
	resulting in desth)	→ ,	Pneumon								Days				
_	DUE TO (OR AS A CONSEQUENCE OF):											1			
<u>ō</u>	Sequentially list conditions, if any, leading to immediate our TO (OR AS A CONSEQUENCE OF):											Months			
CERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or Inju	NG	. Cerebel	lar Atax	ia									Months	
E	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSEC	UENCE OF	ን:									
H	resulting in death) LAS		ı												
	PART II. Other significant conditions contributing to deeth but not recuiting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WER											WERE AUTOPSY FINDINGS			
MEDICAL	Arrhythmia									_	PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE	
빌	Cerebellar	Ataxi	а							_	1 123 2	M NO		OF DEATH?	
1	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 I	NO [	UNG	ERTAIL	V K					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLAC	E OF DEAT										
XS.	1 TES 2X NO		1   Inpetient 2	ER/Outpatient 3	□ DOA	OTHER 4 X Nun		5 🗆 R	sidence	8 🗆 Othe	r (Specify)				
PH	27. MANNER OF DEATH	Pending	28s. DATE OF (Month, Di		28b. TIM	E OF URY	28c. INJI WO			28d. DES	CRIBE HOW I	NJURY OC	CURED		
B	2 Accident	investigation				M		ES 2 [	NO						
		Could not be	26a. PLACE Of building,	F INJURY — At hor etc. (Specify)	ne, farm, a	treet, fact	ory, office			261. LOC City	ATION (Street a or Town, State)	and Number	or Rural Ro	ute Number,	
					<del></del> -		_								
MP I	(Check only		CIAN: To the best of												
3 Suicide 6 Could not be detarmined 26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)  26s. LOCATION (Street and Number or Rural Route Number, City or Town, State)										and menner as stated.					
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Year)															
2	30. NAME AND AODRESS OF		COMPLETED CALL	E OF DEATH STEE	27) /5	Drinel		D 2	7301			1	lay 3	1, 1995	
	Douglas R. S						777	Men	110	Rooles	71110	MD ′	20850		
	31. DATE FILED (Month, Day,	Year)	32. REGISTRA			. 60me	Ly E	7 4 5 11	ue, 1	KUCK'	, TTTE,	rid 2	20030		
	JUN	01 1995	Juliad	AUGULOS NO	roball										
					_										



Pages 1, 2, 3 should

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

notified at

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must

examiner

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

0

1X XVES 2 □ NO

8 Could not be

27. MANNER OF DEATH

1 Natural

2 Accident

3 Suicide

29e, CERTIFIER

95 18722 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 29,1995 MAY TASHA MONIOUE WILLIAMS 13:30 Pm 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 M 2 TF 199-56-6940 OCT. 29,1969 PA. 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES COUNTY HOSPITAL CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PA. PHILADELPHIA PHILADELPHIA 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1836 YEWDALL ST. 19143 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ✓ YES 2 ☐ NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married BY 3 Wildowed 4 Divorced ACTIVE DUTY BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL, OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5+) 12 U. S. NAVY DEFENSE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) ALPHONSO MOUZON BE LEOLA WILLIAMS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LEOLA #10 WILLIAMS SAME AS ITEM 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE FERNWOOD" CEMETERY 64 FERNWOOD, PA. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, W. W. CHAMBERS CO., RIVERDALE, MD. 20737 Approximate shock, or heart fellure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition\_ wards resulting in death) DUE TO (O AS A CONSEQUENCE OF

Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO W UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

001

YES 2 | NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO

28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)

1 X Inpetient 2 - ER/Outpetient 3 - DOA IME OF 28a. DATE OF INJURY 28b. TIME OF

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUBED

28/95 PLACE OF NJURY -- At home to office Bun DING

1 TYES

28f. LOCATION 8101 45

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

2 💢 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due ATURE AND TITLE OF CHATIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month Day Year)

E ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

OCME

MAY 31,1995

TLAFON

PENN STREET BALTIMORE, MARYLAND 21201 111

31. DATE FILED (Month, Day, Year) REGISTRAR'S, SIGNATUR 01 1995 alia Davolson Rardall

· · · And a factor of the second State of the second second 

1 TES 2 X NO

10g. CITIZEN OF WHAT COUNTRY? United States

3. TIME OF DEATH

A

10d. INSIDE CITY 1 YES 2 1 NO

White

20910

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?

Approximate interval Between Onset and Death 2 WEEKS

14. RACE — American Indian, Black, White, etc.

a. BIRTHPLACE (State or Foreign Country)

Pennsylvania

retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be DIVISION OF VITAL RECORDS, P.O. BOX 68760

BY FUNERAL DIRECTOR

BE COMPLETED

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at once.

been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should it, or Health and Mental Hygiene prior to burial, cremation, or removal. 90 must t the medical examiner other traumatic event, Injury, or shows any has be Dept. or Item 23 certificate h

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

CERTIFICATION

PHYSICIAN: MEDICAL

ВУ

COMPLETED

BE

2

2 Accident 3 Suicide

marked,

28 18

this c

After

DIRECTOR: /

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT; If Item 21

1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND /	DEPAR					MENTA		GIENI	E		
1. DECEDENT'S NAME (First	I, Middle, Last)									OF DE				3. TIME OF D
MARY REMINGER WILSON									JUN	ĬF.	1.		95	6:45
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.									-	OF BIRT	,			PLACE (State of
577-48-7206		1 🗆 M 2 😿 F	71	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Y	bar)		Country	y)
9a. FACILITY NAME (If not in			/1		9h CIT	r, TOWN O	D I OCAT	ON OF D	Sept	12,	19			nsylva
The second secon								ON OF D	EATH			9c. COUNT		
Suburban Hospital Bethesda Montgom											mery			
10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	ION							10d. INSIDE (
Maryland		gomery		Ве	thes	da								LIMITS?
10a. STREET AND NUMBER						10f.	ZIP COD	E				10g, CITIZI	EN OF W	HAT COUNTR
6313 Dahlon	ega Ro	ad					2081	6				Unit	ed S	States
11. MARITAL STATUS			TEVER IN U.S. AR		13.	WAS DEC	ENDENT (	OF HISPA	NIC ORIGI	N? (Spec	Ify Yes	or No- 1		— American
1 Never Married 2 X	5-316-5	IF YES, OIVE V		•0		If yes, spe 1 YES				Rican, at	ic.)		Speck	t, White, etc.
3 WILLOWER 4 DIN	лсец													Whit
	EDENT'S EDU		16a. DE	CEDENT'S	USUAL O	CCUPATIO	N st of worki	na	16	b. KIND C	F BUS	HNESS/INDU	STRY	
Elementary/Secondary (	0-12)	College (1-4 or 5	+) life.	Do NOT us	se retired.)									
		5+	Pub.	lic Af	fairs	: Assi	stant	,	l	J.S.	St	ate D	epa:	rtment
17. FATHER'S NAME (First, A	fiddle, Last)						18. MOT	HER'S NA	ME (First,					
John			Reminge	r			Rho	da				Sch	rac	<
19a. INFORMANT'S NAME (			198	b. MAILINO	ADDRES	S (Street at	nd Numbe	r or Rural	Route Nun	ber, City	or Town	, State, Zip C	(ode)	
J. Randolph	Wilso	n (Husb	and) S	ame	as #	10								
20a. METHOD OF DISPOSIT		aumi danum Chada	20b. PLACE	ANDDATE	OF DISPOS	SITION (Na	me of		OAT	E 20	Dc. LOC	CATION — CI	ty or To-	wn, State
4 Donation 5 Other		over from State	Chesa	matory or or peak	ther place) <b>e Cr</b>	emat	orv		6/1/	95 F	Bel:	tsvil	le.	MD
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENDEE /			22.	NAME AN	O ADDRE	SS OF FA	CILITY					110
D 1/	121		1,110			app								
1 det	-12.6	ey		0827		33 G	ist	Ave,	Sil	ver	Sp	ring,	MD	2091
	eart fallure.	complications the List only one cau	t caused the de use on each line	eth. Do n	ot enter	the mod	de of dy	ing, suc	h aa car	dlac or	reapir	retory arres	nt,	Approx
IMMEDIATE CAUSE (Find disease or condition	nal	1 1 11	NG C	$\neg \wedge$	NI		<b>-</b>							Onset
resulting in death)	<b>→</b>		701	$\nearrow$	11/1		1<	•						ZW
		DUE TO	(OR AS A CONSEC	DUENCE OF	F):									
Sequentially list condit	Iona.	b												
If any, leading to imme	diate	OUE TO	(OR AS A CONSEC	DUENCE OF	F):									
Cause. Enter UNDERLY CAUSE (Disease or inju														
that initiated eventa resulting in death) LAS		DUE TO	(OR AS A CONSEC	DUENCE OF	F):									
. vesicing in death) LAS		d		-										
PART II. Other algoritics	nt condition	e contributing to	death but not a	asultine !	n the	ada dada -		nlua- t-	Don't !			4177077		
				overtung t	iii tile ul	-conying	vause !	Aradii IU	FARL I.		REFORE	AUTOPSY MED?	240.	WERE AUTOPS

1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [] 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 XCNO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdence 6 - Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 5 Pending investigation 1 X Naturel 1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. CERTIFIER
(Check only one)

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

D39966

6111 Executive Blvd, Rockville, MD

1	17	MI	ME	TT	MD			
30	NAME AND	ADDRESS	OF PERSON	WHO COMP	ETED CAUSE OF	E DEATH STEM OF	(T	Orient

Carolyn A. Hammett, M.D. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

JUN 02 1995

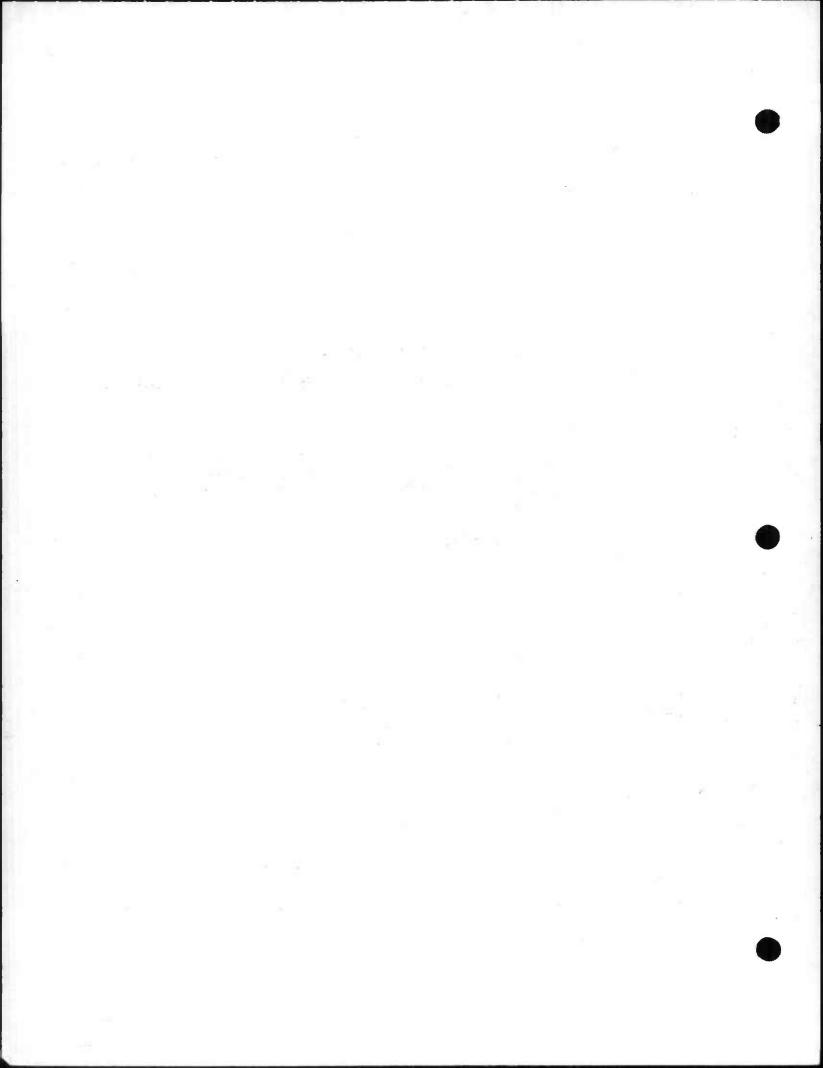
SIGNATURE AND TITLE OF CERTIFIER

6 Could not be

DHMH-16 Rev 1/89

20852

29d. DATE SIGNED (Month, Day, Year)



Pages 1, 2, 3 should

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burnal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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2

ACCRESS OF PERSON

02 1995

AROW

31. DATE FILED (Month, Day, Year)

95 18724 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3 T 1955 9:45 A. WALLACE WILLIAM NEAL 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign HOURS 219-48-6015 1 X M 2 - F 50 YRS. Oct. 12,1944 Washington D.C Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES 13535 TURKEY BRANCH PARKWAY ROCKVILLE RESIDENCE OF DECEDENT 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery 1 YES 2 X NO Rockville FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13535 Turkey Branch Parkway 20853 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Merried 2 Married BY Specify: 3 Widowed 4 Divorced Vietnam White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 0wner Pharmaceutical 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Elmer N. Wallace BE Margaret Clancy 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Terry S. Flynn 13535 Turkey Branch Pkwy. Rockville, Maryland 20853 20e. METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Metropolitan Crematory 4 ☐ Donetion 8 ☐ Other (Specify) 6/5/95 Alexandria, Virginia 21. SIGNATURE-OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr. MD 20901 23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disease or condition COM resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significant conditions contributing to death but not recuiting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 XYES 2 NO Inpatient 2 - ER/Outp 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 X YES 2 | NO BY shier 2 Accident 3 Suicide 28e. PLACE OF INJURY — At he hullding, etc. (Specify) 281. LOCATION (Street and A COMPLETED 8 Could not be determined 43 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and ma MEDICAL EXAMINER: On the death occured at the time, date end place, end due to the ceuse(e) end manner ee stated. MATURE AND TITLE OF CERTI 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE

WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. REGISTRAR'S SIGNATURE

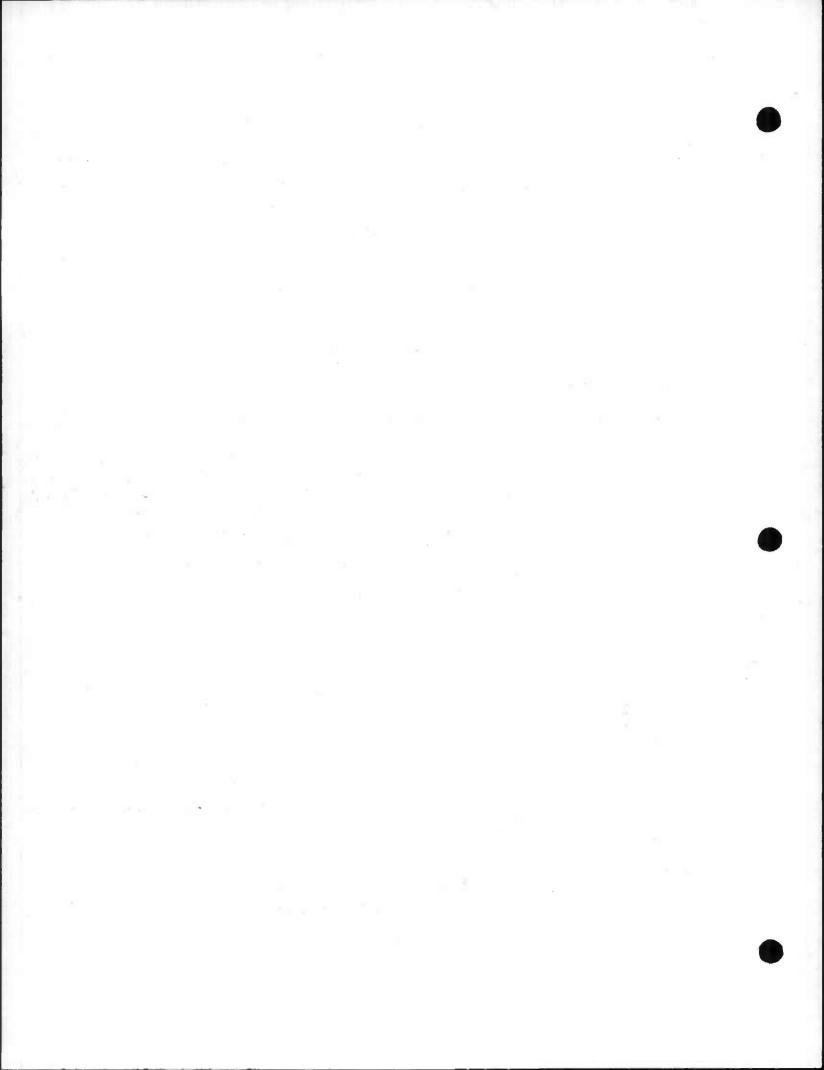
M.

Jolis Davidson Rad 11

DHMH-18 Rev 1/89

1995

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BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing fours after death. Page 6 may be retained by the hospital or attending physicial	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-te
	ours a	led in b
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The law requires that the death certificate be executed within	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
DIVISION OF VITA	L OR ATTENDING PHYSICIAN: Th	DIRECTOR: After this certificate

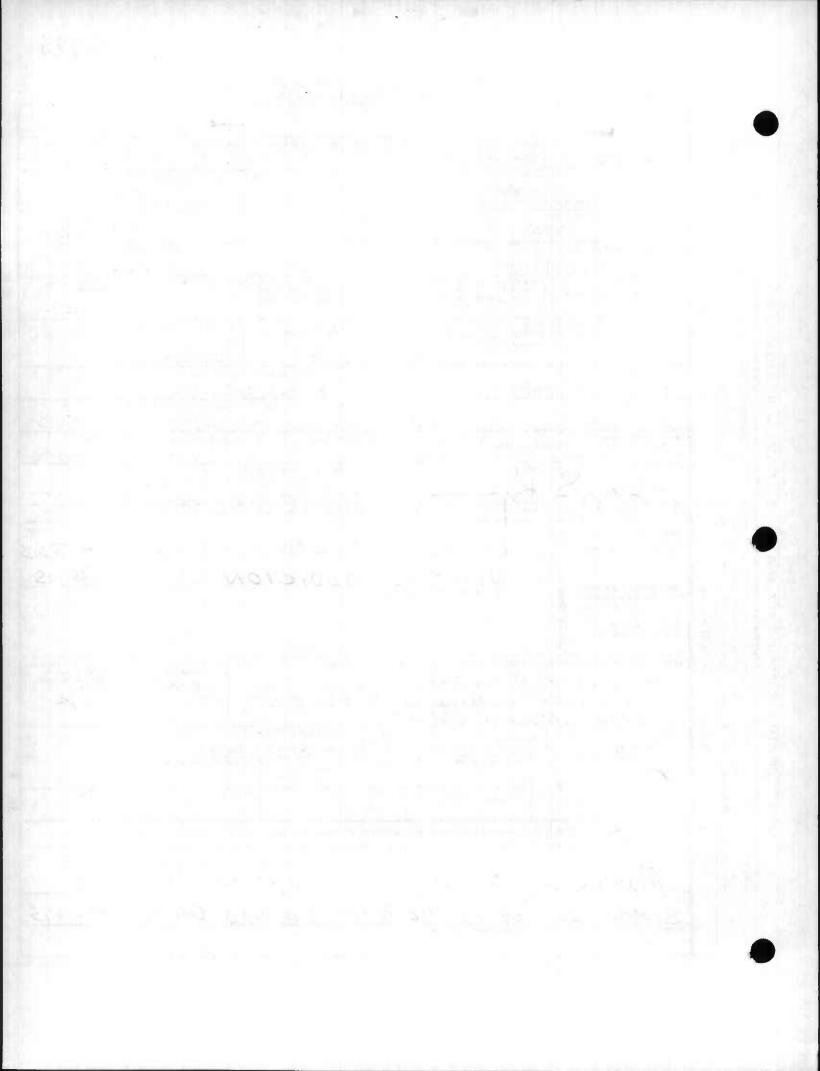
as the burial-transit permit. Pages 1, 2, 3 should ttending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hoss TO THE PUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE REGISTRAR

1 -

STATE OF	MARYLAND / DEPARTMENT			MENTAL	HYGIEN	E
	CERTIFICATE	OF DEAT	H		REG. NO.	
-4)						

4. SOCIAL SECURITY NUM	Allen W	laskey							June 7	, 199	5 YEAR	year 3. TIME OF DEATH 11:30 a M					
4. SOCIAL SECURITY NUMBER 5. SEX 1X M 2			6. AGE (In yes. la 48	"	IF UNDER	DAYS	IF UNDER 24	HRS.	7. DATE OF BII (Month, Day, Apr. 29	RTH (Mear) 194	Count	ryland					
98. FACILITY NAME (II not ) 7281 Oaklar RESIDENCE OF DE	nd Mill					olun	n LOCATION	OF DE	ATH	9c.	Howard						
Maryland	Maryland Howard					bia						10d. INSIDE CITY LIMITS? 1 YES 2 NO					
	7281 Oakland Mills Road  11. MARITAL STATUS  12. WAS DECEDENT EVER IN						21046				U.S.A.						
1 Never Merried 2 3 Widowed 4 Div	T EVER IN U.S. AI YES 2 XX AR OR DATES	RMED NQ	11	yes, sp	cify Cuben,	NISPANI Mexican Specify:	IC QRIGIN? (Spe i, Puerto Rican,	ecify Yes or N atc.)	Biac	14. RACE — American Indien, Black, White, etc.  Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  Grade 4  College (1-4 or 5 +)				ECEDENT'S L Give kind of w e. Do NOT use Ckhoe	ork done d retired.)	luring mo	st al working		Cor	nstruc	ness/industry ruction						
17. FATHER'S NAME (First, A Ernest Will					Mar	уЕ	thel Si	mith									
Susan Waske		7281	Oakl	and	Mills			olumbi		ryland 2104							
1   Burtel 2   Cremetil 4   Donation 6   Othe 21. SIGNATURE OF FUNERA	cometery, cr	ematory or oth	ner place) mato	YAME AN	D ADDRESS		6/8	Cator	nsville	own, state e, Maryland							
23. PART I. Enter the	2/5	. Kgr			3	13 7	albot	t A	eral Ho venue	Laure	el, Man	cyland 2070					
resulting in death)  Sequentially list condi	(OR AS A CONSE	GUENCE DF	):	AD	DIE	Ták	) N			Zoyrs							
cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSE														
PART II. Other algorific  O LO  S UP &  CO LO  S UP &  CO LO	ant condition  5785  NAME  NAM	a contributing to		PIS	the un		) cause glv	ren in f		WAS AN AUTO PERFORMED YES 2	7	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES NO					
Cause. Enter UNDERLY CAUSE (Disease or Injithat initiated events resulting in death) LASPART II. Other algoritic.  PART II. Other algoritic.  D   A B   C O NO S   S UP = 25. WAS CASE REFERRED EXAMINER? 1   YES 2   NO	ant condition  5785  NAME  NAM	a contributing to  MEL  ANT  ONS IN  HOSPITAL:  1   Inpetient 2	deeth but not	PIS	OTHER	26. PL	ACE OF DEA	TN (Che	ck only one)	YES 2	?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
Cause. Enter UNDERLY CAUSE (Disease or Injute initiated events resulting in death) LAS PART II. Other algnific  DIA BO  CO NO  25. WAS CASE REFERRED 1 EXAMINER? 1 YES 2 NO  27. MANNER OF DEATN 1 Setural 5  2 Accident	ant condition  TES  NYIW  TO MEDICAL  Pending investigation	A CONTRIBUTING TO MELL AND IN HOSPITAL:  1   Inpetient 2   28a. DATE OF (Month, D)   28a. PLACE C	deeth but not LITUS LITU	P / S S / 7	OTHER 4   Nurs	26. PL	ACE OF OEA  • 6 Treek	TN (Che	ck only one)  B Other (Spec 26d. DESCRIBE	YES 2 DON	Y OCCURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES NO					
Cause. Enter UNDERLY CAUSE (Disease or Inji that intilated events resulting in death) LAS  PART II. Other algnific  DIABO  CONO  SUPE  25. WAS CASE REFERRED 1 EXAMINER? 1 YES 2 NO  27. MANNER OF DEATN 1 Setup 5 2 Accident 3 Suicide 6 4 Homicide  29e. CERTIFIER (Check only)	ant condition  TO WEDICAL  Pending Investigation  Could not be datermined  TITYING PNYSI	a contributing to  MEL  AND  HOSPITAL:  1 Inpetient 2  28a. DATE OF  (Month, D  28b. PLACE Of building,	deeth but not LITUS ULMU OBC  OBC  INJURY INJURY—At hetc. (Specify) my knowledge, d	D / S S / T   3   DOA   28b. TIME INJU ome, farm, st	OTHER  OTHER  OF INT  M  reet, factor	26. PL	ACE OF OEA  • 6 Procedure  • 7 Procedure  • 8 Procedure  • 8 Procedure  • 9 Procedure  • 1 Proce	TN (Checker)	1   1   1   1   1   1   1   1   1   1	YES 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Y OCCURED  The stated,  The to the cause(	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES NO					



58750, BALTIMORE, MARYLAND 21215-0020	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, a within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	RTANT: If liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	e death certificate be executed with	he attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or remova	jury, or other traumatic event, the medical
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 3 within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	NT: If item 28 is marked, or Item 23 shows any in
DIVISIO	E HOSPITAL OR ATTENDINE	E FUNERAL DIRECTOR: After dear dear	RTANT: If item 28 is m

resulting in death) LAST

27. MANNER OF DEATH

1 Natural

2 Accident 3 Sulcide

4 Homicide

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: I

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 1, 1995 Wint Elmo Walls June 4:45 A.M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
NOV. 5, 1906 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Virginia 215-05-3896 1 M 2 F DAYS 88 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bel Forest Nursing & Rehab. Center Forest Hill Harford RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Bel Air 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 413 Prospect Mill Road 21015 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: 1 TES ZONO Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 6 Operating engineer Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Hughy (u/k)Walls BE unknown 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 405 Prospect Mill Road, Bel Air, Maryland 21015 Ronnie J. Walls 20s. METHOD OF DISPOSITION

1 N Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Bel Air Memorial Gardens 6/3/95 Bel Air, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. Kuch 1317 Cokesbury Road, Abingdon, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximsta shock, or heart fallure. List only one cause on each line Interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Obstructive Pulmonary Disease Chronic 10 year DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events

PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovascular 1 TES 2 1 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

28b. TIME OF

INJURY

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? OF DEATH?

281. LOCATION (Street end Number or Rural Route Number, City or Town State)

1 TYES 2 THO

OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO

29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of average o MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the films, data end place, and due to the cause(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

	13	ah	H	h	ld	m	(3)		
90.	NAME AND	ADDRESS C	F PERSON	WHO	COMPLETED	CAUSE OF	DEATH (I	TEM 27) (Type,	Prir

HOSPITAL:

Investigation

8 Could not be determined

135522 Bel Air Maryland

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

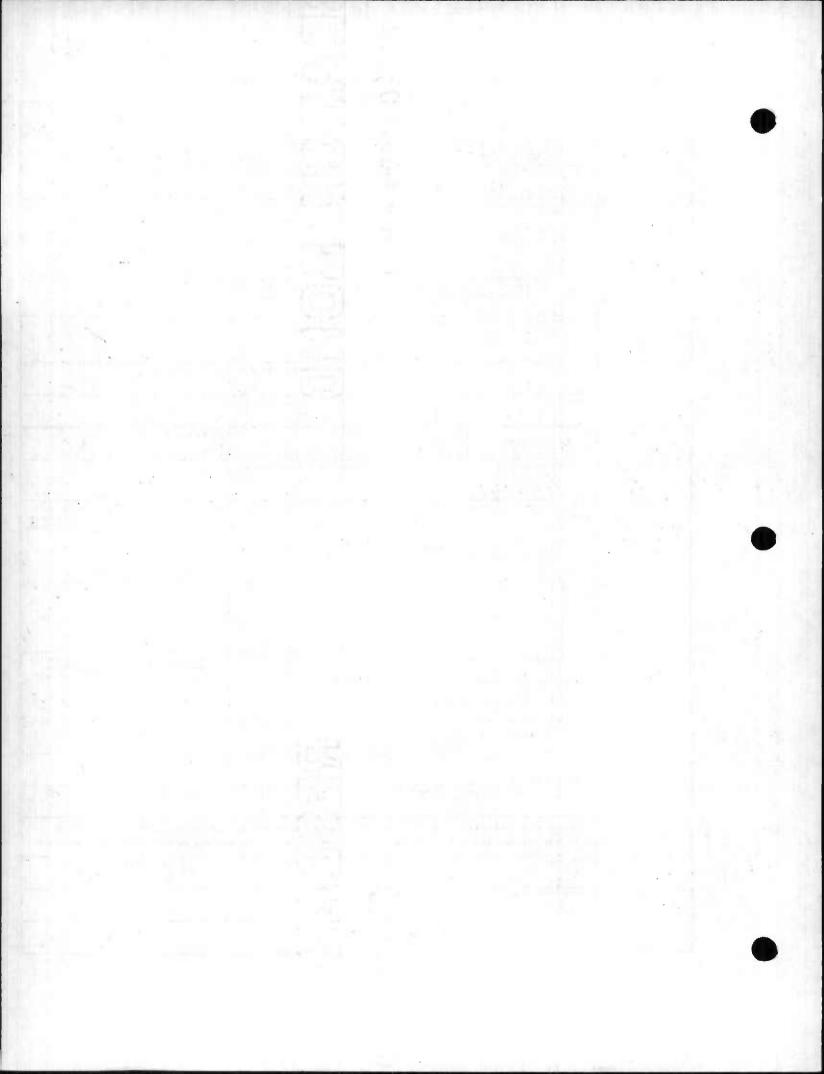
Mark Wild 2 North Avenue

122. REGISTRAR'S SIGNATURE

1 | Inpatient 2 | ER/Outpatient 3 | DOA

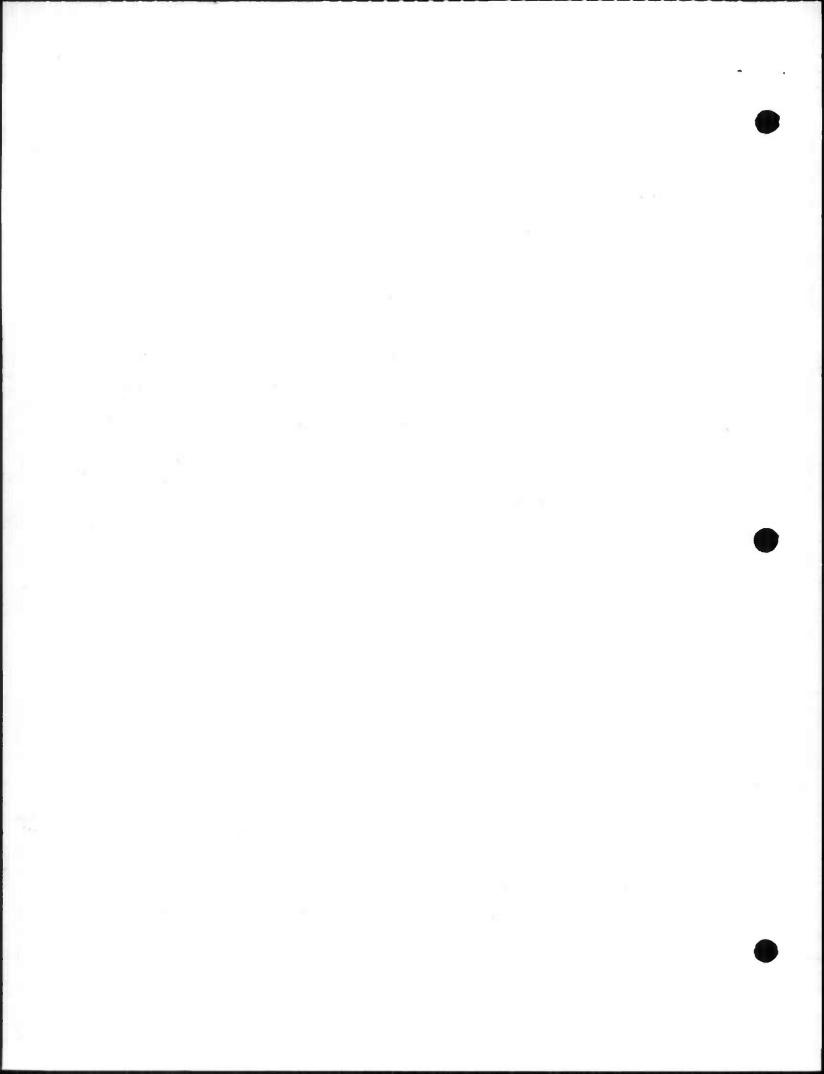
28e. DATE OF INJURY (Month, Day, Year)

31. DATE FILED (Month, Day, Yber) JUN 0 2 1995



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DIVISION
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTA CERTIFIC	IENT OF H	IEALTH AND		HYGIENE REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Lest) ROMAINE MA					2. DATE OF MONTH June	DEATH	995 "	3. TIME OF DEATH 1:30 a.m		
	4. SOCIAL SECURITY NUMBER 219-20-4128	1 □ M 2 € F 7	O YRS.	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D May	BIRTH (29), Year)	25 1	BIRTHPLACE (State or Foreign Country) MD .		
TOR	98. FACILITY NAME (If not institution, give to Carroll County RESIDENCE OF DECEDENT				ninster		ec. COUNTY OF DEATH  Carroll				
DIRECTOR	10a. STATE 10b. COUNT	arroll		OWN OR LOCAT		100. 110102 01					
FUNERAL	100. STREET AND NUMBER 1000 Meadow E	Branch Rd.		101	21158			USA	OF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPAI ecify Cuban, Maxica 2 NO Specif	ENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American India: Black, White, atc.   No Specify: White.					
COMPLETED	15. DECEDENT'S EDU. (Specify only highest grade Elementary/Secondery (0-12)	JAL OCCUPATION done during months in the control of	ON at of working	n/a							
BE COM	17. FATHER'S NAME (First, Middle, Last) Charles Henry	Smith			10. MOTHER'S NA				ime		
TO B	198. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code) Paul Wisner 901 Old New Windsor Rd., Westminste										
	20e. METHOO OF DISPOSITION  1X Burlai 2 Cremetion 3 Removal from State  4 Donation 6 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery or other place)  Trinity U.C.C. Cem. 6/7/95 Manchester										
	21. SIGNATURE OF FUNERAL SERVICE LI	Lemm	er	West	minster	, Md.	211				
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  Due to (or as a consequence of):										
PHYSICIAN: MEDICAL CER	PART II. Other algorificent condition  DID TOBACCO USE CONT		1	PERFORM	ED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2  NO	HOSPITAL:	26. PLACE OF OEATH (C	Check only one)							
/ PHYS	27. MANNER OF DEATH  1 Natural 5 Pending	1   Inpetient 2   ER/Outp	28b. TIME OF	28c. INJ WO	• 5 Realdence URY AT RK? 'ES 2 NO		pecify)	URY OCCUR	ED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be datermined	28e. PLACE OF INJURY building, etc. (Spec	— At homa, farm, stree			261. LOCATIO	ON (Street and fown, Stete)	d Number or F	Approximate Interval Between Onset and Death Lawrent Between Onset and Death Lawrent Between Onset and Death Lawrent Between Onset and Death Lawrent Between Onset and Death Lawrent Between Completion of Completio		
COMPLET		ICIAN: To the best of my knowl ER: On the basis of examination							ause(a) end manner as stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	and m	O NTH (ITEM 27) (Type, Priv	1)	29c. LICENSE NUI				GNEO (Month, Day, Year)		
	Stephen J. Sik		., 912 W		gton Rd	., We	estmi	nste	r, Md. 21157		
		i d'aucharharla	U <sub>C</sub>								



		REGISTRAR				CERTIF	ICATE	: OF	DEATH		REG. NO			
		1. DECEDENT'S NAME (First, Middle,	Last)			- 1				2. DATE	OF DEATH	AV	YEAR 3	TIME OF DEATH
		Lawrence		E		Ward				Jur		1995		4:00 AM M
		4. SOCIAL SECURITY NUMBER		5. SEX	The second	yrs. lest birthday)	IF UNDER	_	IF UNDER 24 HRS.	7. DATE	OF BIRTH		A. BARTHPL	ACE /State or Foreign
P		244-12-5323		1 X M 2 ☐ F		79 YRS.	MONTHS	DAYS	HOURS MIN.	Dec.	12,1	915	North	Carolina
should										N OR LOCATION OF DEATH 9c. COUNTY OF DEATH				
62	O.	Charles County Nursing Home LaPlata Charles												
<del>-</del> "	5	RESIDENCE OF DECEDEN	IT										arics	·
Pages	DIRE		OUNTY				Y, TOWN O		FION				10	Dd. INSIDE CITY LIMITS?
permit.			Pri	nce Geor	ge's		Clin	ton					1	YES 2 NO
De la	MA I	10e. STREET AND NUMBER						101	. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
physician. burlal-transit	FUNERAL	9320 Pella Pl	ace						20735			Unit	ed St	ates
physician. burial-trar	5	11. MARITAL STATUS  1 Never Married 2 XMarried	U.S. ARMED 2 NO	13. V	MAS DEC	ENDENT OF HISPAI	NIC ORIGIN	? (Specify Yes			American Indian, Vhite, atc.			
		3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:										Specify:		
60 10	ED	BLack										ack		
>	ETE	(Specify only highest	(Give kind of life. Do NOT u	work done d	luring mo	st of working	166.	KIND OF BUS	SINESS/IND	USTRY				
of for	12	Elementary/Secondary (0-12) College (1-4 or 5+)  12  Maintenance									12			
the hospital detached fo	COMPL	17. FATHER'S NAME (First, Middle, La.	ef)			Mainte	lance	Enc			overn			
at of at		H T 00 77 7							18. MOTHER'S NA			Surname)		
	8	19a. INFORMANT'S NAME (Type/Print)				10h MAII IN/	ADDRESS	(Oten et e		Smit				
2 2 2	2	Ruth N. Ward							nd Number or Rural					
a so h					200 5	19320 1	етта	PT	ace, Climodune 9	nton	Maryla			
3 8 0 (		29a METHOD OF DISPOSITION  1-13 Burlal 2 Cremation 3 C		ral from State	cerne:	tery, cremetory or c	ther place)	HONING	oune 9	, 1995			City or Town	
Page Il dire	1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY LEE  22. NAME AND ADDRESS OF FACILITY LEE  23. NAME AND ADDRESS OF FACILITY LEE  24. NAME AND ADDRESS OF FACILITY LEE  25. NAME AND ADDRESS OF FACILITY LEE  26. NAME AND ADDRESS OF FACILITY LEE  27. NAME AND ADDRESS OF FACILITY LEE  28. NAME AND ADDRESS OF FACILITY LEE  29. NAME AND ADDRESS OF FACILITY LEE  20. NAME AND ADDRESS OF FACILITY LEE  21. SIGNATURE OF FUNERAL SERVICE LICENSEE										Ltenh	am, M	aryland
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Per of		23. PART T. Enter the diseases shock, or heart fall	or co	mplications the	t caused	the death. Do	not enter	the mo	de of dying, suc	h aa card	lac or respi	ratory arre	eat,	Approximats
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nding phy Hygiene propriet	F	that initiated events resulting in death) LAST		DUE TO	(OR AS A C	CONSEQUENCE O	F):							
	EH		d.											
We be		PART II. Other significant cond	ditions	contributing to	death but	t not resulting	in the unc	derlying	csuse given in	Part I.	24a, WAS AN	AUTOPSY	24b. WI	ERE AUTOPSY FINDINGS
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PHYSICIAN: The this certificate hi with the State C	SICI	EXAMINER?		HOSPITAL:	ER/Output	Harri 3 🗆 DOA	OTHER	i Inn Ham		4 C 400				
SICIA certif	РНҮ	27. MANNER OF DEATH		28a. DATE DF	INJURY	28b. TIM	E OF	28c. INJ	e 5 Residence		(Specify)	NJURY OCC	URED	
NG PHYS fter this c eath with marked		Natural 5 Pending	don	(Month, D	wy, Ybar)	IN.	M		RK? 'ES 2 ND					
VDING : After r death	D BY	2 Accident Investigat 3 Suicide 6 Could no		28e. PLACE D	F INJURY -	- At home, ferm,	street, facto	ry, office		281. LOCA	TIDN (Street a	ind Number	or Rural Rout	Number.
28 af 10 1	ш	4 Homicide datermin		building,	etc. (Specify	y)				City o	r Town, State)			
OR A DIREC hours	LET	29a. CERTIFIER 1 CERTIFYING	PHASIC	ANI To the heat of	- to suite	des desta								
<b>₫₫₽</b>	COMPL								and place, and dua					nd menner as stated.
HOSPITAL FUNERAL Within 72 TANT: If	8					- Investigation	п, ш пу ор	minori, o	satir occurso at the	time, data	eno pieca, an	d due to the	cause(a) ar	nd menner as stated.
를 보를	H	296. SIGNATURE AND TITLE OF CER	TIFIER	1. M	000				29c. LICENSE NUI	MBER		29d. DATE	SIGNED (M	onth, Day, Year)
663₹	2	30 NAME AND ADDRESS OF SPECIA	N Mare	COMBI	الرامو				N793	51		_	6-5	795
	.	30. NAME AND ADDRESS OF PERSO Krishan Ma						212	Waldows	Mess				
	1					7.	#	213	Waldorf	, Flair	Arquq			
S .		JUN 0 6 19	95	Javao	Danal A	or Randall								
		0000 10		10										

8. BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

Approximate

WERE AUTOPSY FINOINGS

COMPLETION OF CAUSE

1 YES 2 NO

OF DEATH?

intervai Between

**Onset and Death** 

Operation

1 YES 2 NO

Connecticut

1995 YEAR

9c. COUNTY OF DEATH

U.S.A.

Frederick

10g. CITIZEN OF WHAT COUNTRY?

1914

2. DATE OF DEATH

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ALCO, P.O. BOA 607 607	hat the death certificate be executed with the start death. Page 6 may be retained by the hospital or attending	by the attending physician and complement in by the funeral director name 5 should be detached by use as the

BE

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

IGNACE HARRISON WILLIAMS June 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTIN (Month, Day, Year) 1 X M 2 🗆 I DAYS HOURS 041-05-5904 80 YRS. July 16, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give etre 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 8108 Edgewood Church Road Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c, CITY, TOWN OR LOCATION Maryland Frederick Frederick permit. FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 21702 8108 Edgewood Church Road **burial-transit** 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 YES 2 XNO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15, DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) 1 Vear Steamfitter None 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) John Williams Elizabeth Unknown BE notified 19e. INFORMANT'S NAME (Type/Print) 19th MAILING ADDRESS (Street end Number or Rural Route Number, City or Rown, State, Zip Code)
8108 Edgewood Church Road Frederick, MD 21702 2 Betty B. Williams be 29a. METHOD OF DISPOSITION
1 Burial 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c, LOCATION - City or Town, State OATE must 4 Donation 5 Other (Specify) Mount Olivet Cemetery 6/3 Frederick, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, the medical 23. PART I. Enter the diseases, or complications that cause the death. Do not enter the mode of dying, auch sa cerdiec or respiratory arrest, shock, or heart fellure. List only one cause each line cremation, or IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic event, to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING prior CAUSE (Disesse or injury Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 Injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL and any Signed 1 TYES 2 TH Shows pt. of h the State Dept. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** L. OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate 2 hours after death with the State filtern 28 is marked, or liter OTHER: 1 | YES 2 | 10 1 Inpatient 2 ER/Outpatient 3 DOA ne 5- Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED 1 Naturel 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 6 Could not be 281. LOCATION (Street end Number or Rural Route Number, Cltv or Town, State) COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. HOSPITAL FUNERAL I 2 MEDICAL EXAMINER: On the b TO THE HOSPITA
TO THE FUNERA
De filed within 7. vestigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND STILE OF CERTIFIER 25c. LICENSE NUMBER

30. NAME AND AGORESS OF PERSON WHO COMPLETED GAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Ali James Afrookteh

JUN 0 5 1995

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

300 West 9th Street Frederick, Maryland 21701

**DHMH-18 Rev 1/89** 

31. DATE JUN 14 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE SECRETIFICATE OF DEATH  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATE  SECRETIFICATION  SE	ITEMS: 23 PA	RT I, 27, 2	8a-f, PER	MEO F	ILM G-	724	6/14/95	t.t		9:	)	8130	
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15.4 38 6328			6. AGE (In vrs. las							1 :			
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Apt. 32—J Richmar Road    11. MANIAL STATUS	,	TIMOLE			WING	_					YES 2 □ NO		
T. MARTAL STATUS   T. MARTHAL STATUS   T. MA	A .	D 1				101.		1117		10g. CI	TIZEN OF	WHAT COUNTRY?	
Second   Part   Second   Par		ir koad						111/		Un	ited	States	
Windows   Decreed   If YES, GIVE WAR OR DATE		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. W	AS DECE	NDENT OF HI	SPANIC ORIGI	N? (Specify Ye	s or No-	14. RAC	E — American Indian,	
Sequentially   Sequ	1 Never Married 2 Married	IF YES, GIVE V	MAR OR DATES						Rican, etc.)		1		
Elementary/Tisscondary (0-11) College (1-d or 5+)  Elementary/Tisscondary (0-11) College (1-d or 5+)  Pair Stylist  Is. MOTHER'S NAME (First, Mickin, Last)  Kasmir W. Witkiewicz  Helen M. Guzoski  196. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  196. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  196. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  196. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  197. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  Kasmir W. Witkiewicz  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocke)  198. MARJING ADDRESS (Street and Number or Plum Revolus Number, City or Bown, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Zip Cocken, Stein, Zip Cocken, Stein, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip Cocken, Zip	3 Widowed & Divorced			No					No				
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Note:   Note		2	Ha	air S	tvlis	st			Hair	Sal	on		
Name   Name	17. FATHER'S NAME (First, Middle, Last)				-/	T	18. MOTHER	S NAME (First.	Middle, Maider	Sumame)			
The MARLING ADDRESS (Street and Number or Parall Route Number, City or Rev.). Steak, Zip Code)  Kasmir W. Witkiewicz  20a. METHOD OF DISPOSITION  20a. METHOD OF DISPOSITION  20b. PLACE OF BEATH (Processing)  20b. PLACE OF DEATH (Processing)  21c. Name AND ADDRESS (Street and Number or Parall Route Number or Paral Review Number or Parall Route Number or Paral Review Number or Paral Revie	Kasmir W. Witki	ewicz											
RASMIT W. Witkiewicz   1558 Bandury Court Crofton Maryland 21114		CWICZ	1 101	MAII INC	ADDRESS	(Charact a s							
20b. PLACE AND DATE OF DISPOSITION   20b. PLACE AND DATE OF DISPOSITION   Name of committery, committery, committery of committery, committery of committery, committery of other placed   20b. PLACE AND DATE OF DISPOSITION   Name of committery, committery of other placed   20b. PLACE AND DATE OF DISPOSITION   Name of committery, committery of other placed   20b. PLACE AND DATE OF DISPOSITION   Name of committery of other placed   20b. PLACE AND DATE OF DISPOSITION   Name of Committery of the placed   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE AND DATE OF DISPOSITION   Name of Committery   20b. PLACE OF DEATH   Name of Co	STATE OF THE STATE												
Sequential   Security   Committee   Comm	The state of the s												
23. PART I. Enter the diseases, or complications that cauded the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feiture. List only one cause on each line.  IMMEDIATE CAUSE (Final diseases, or complications that cauded the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, indexed above. In the conditions resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter NIDERLYING CAUSE (Disease or injury that inflitted events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE	15 Buriel 2 Cremetion 3 Re	15 Burlei 2 Cremation 3 Removal from State										own, State	
Robert E. Evans Funeral Home, P.A.  16000 Annapolis Rd. Bowie Md. 20715  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between Constitutions and the disease or condition resulting in death)    MARCOTIC 'INTOXICATION   DUE TO (OR AS A CONSEQUENCE OF):	Resurrection Cemetery 6/2/95 Clinton Maryland												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final Management of	21. SIGNATURE OF FUNERAL SERVICE I	0	in Pa	les	Ro	ober	t E. H	Evans :					
Interval Betwee Onset and Date of Cause (Principle of Cause Constitution on Cause Dro each line.    MARCOTIC INTOXICATION	23. PART I. Enter the diseases, o		/ / -	ath. Do n	of enter t	be mod	Annaj	Such as cer	diac or reen	wie i	Md. Z		
disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):	ahock, or heert fellure	. List only one cau	se on each line.				o or aying,		and or resp	matory an		Interval Between	
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DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST  d.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  25. WAS CASE REFERRED TO MEDICAL  EXAMINER? 1 YES 2 NO  THER: 1 Inpatient 2 ER/Outpatient 3 DOA A Noursing Home 5 X Residence 6 Other (Specify)  27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation 3 DOA A Noursing Home 5 X Residence 6 Other (Specify)  28d. DESCRIBE HOW INJURY OCCURED SUBJECT INGESTED DRUGS  28d. DESCRIBE HOW INJURY OCCURED SUBJECT INGESTED DRUGS  28d. CERTIFIER CRETTIFIER CRETTIFIER CRETTIFIER CERTIFIER CERTIFIER  CE		c											
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO  26. PLACE OF DEATH (Check only one) 1 YES 2 NO  27. MANNER OF OEATH 1   Natural   5   Pending Investigation   5   Pending Inv	resulting in death) LAST	d.											
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify)  27. MANNER OF GEATH 1 Natural 5 Pending Investigation 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify)  28. DATE OF INJURY AT WORK? 5 Pending Investigation 6 DO SUBJECT INGESTED DRUGS 29. Accident 1 YES 2 NO  28. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)  28. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 32 RICHMAR ROAD  29. CERTIFIER 1 CERTIFIER 1 CERTIFIER TO THE DEST OF TWO BEST OF TW	M								\/			COMPLETION DF CAUSE	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN   25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  1 Inpatient 2 ER/Outpetient 3 DOA  26. PLACE OF DEATH (Check only one)  OTHER:  1 No THER:  1 Inpatient 2 ER/Outpetient 3 DOA  1 Nursing Home 5 X Residence 6 Other (Specify)  27. MANNER OF OEATH  1 Netural 5 Pending Investigation I									1				
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 X YES 2 NO  1 Inpatient 2 ER/Outperient 3 DOA  27. MANNER OF GEATH  1 Netural 5 Pending Investigation 3 Suicide 6 XICould not be determined  28e, PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)  28e, PLACE OF INJURY — At home, farm, street, factory, office City or Youn, State) 32 RICHMAR ROAD  29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEA	TH YE	SΠN	οП	UNCERT	TAIN []	1		ł		
1 Netural 5 Pending Investigation 2 Accident 3 DA A Number of FUU evaluer 1 Netural 5 Pending Investigation 3 Suicide 6 Millor FUU evaluer 1 Netural 5 Netural 6 Netur	25. WAS CASE REFERRED TO MEDICAL												
27. MANNER OF OEATH  1 Natural 5 Pending Investigation 2 Accident 1 Vestigation 2 Suicide 4 Homicide 6 Million of the determined 2 PLACE OF INJURY At home, farm, street, factory, office 2 Suicide 6 Million of the determined 2 POUND AT HOME 2 Suicide 8 Million of the determined 2 Suicide 6 Million of the determined 2 Suicide 8 Million of the determined 2 Suicide 8 Million of the determined 2 Suicide 8 Million of the determined 2 Suicide 8 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 6 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 8 Million of the determined 3 Suicide 3 Million of the determined 3 Suicide 3 Million of the determined 3 Suicide 3 Million of the determined 3 Suicide 3 Million of the determined 3 Suicide 3 Million of the determined 3 Suicide 3 Million of the			EB/Outpatient 2		OTHER:		- V						
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2 Accident 3 Suicide 4 Monicide 6 MOCould not be detarmined 28e, PLACE OF INJURY — At home, farm, street, factory, office 28	1 Netural 5 Panding (Month, Day, 19er) WORK?												
4 Homicide detarmined building, atc. (Specify)  FOUND AT HOME  29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1 Natural 5 Pending	2 Accident Investigation 2-29-95 FOUND 4:46 P M 1 YES 27/2 NO SUBJECT INGESTED DRUGS											
294, CERTIFIER   CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	2 Accident Investigation		28e, PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)					281. LOCATION (Street and Number or Flural Ro				De de Marcha	
29a, CERTIFIER [Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	2 Accident Investigation 3 Suicide 6 (X)(Could not be	28e, PLACE O	atc. (Specify)			,,		City	or Town, State	32 DI	CHMAD	POAD	
One) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	2 Accident Investigation 3 Suicide 6 (X)(Could not be	28e, PLACE O	atc. (Specify)			,		City		32 RI		ROAD	
The same and the s	2 Accident Investigation 3 Suicide 6 XXCould not be 4 Homicide detarmined	28e, PLACE O building,	etc. (Specify) FOL	UND AT	HOME		nd place, and	REIS	STERSTON	32 RI		ROAD	
	2 Accident 3 Sulcide 4 Homicide  29e. CERTIFIER CORRES only  1 CERTIFIER	28e, PLACE O building,	my knowledge, des	UND AT	HOME	e, data a	nd place, and	REIS	MERSTON	N. MD	ded.	ROAD	
1 2 Section (Section Cont.) (Section Cont.) (Section Cont.) (Section Cont.)	2 Accident 3 Suicide 4 Homicide  299. CERTIFIER COnes only 2 MEDICAL EXAMIN	28e, PLACE O building, SICIAN: To the best of elements	my knowledge, des	UND AT	HOME	e, data a	nd place, and with occursed at	REIS	MERSTON	N. MD	ded.	ROAD	
0.C.M.E. May 30 1995	2 Accident 3 Sulcide 4 Homicide  29e. CERTIFIER CORRES only  1 CERTIFIER	28e, PLACE O building, SICIAN: To the best of elements	my knowledge, des	UND AT	HOME	ne, data a Inion, des	Wh occurred at 29c. LICENSE	City REIS due to the car the time, date NUMBER	MERSTON	7 32 RI M. MD noner and action and observe to the	e ded. he cause(x	ROAD  and manner as stated.	

Penn

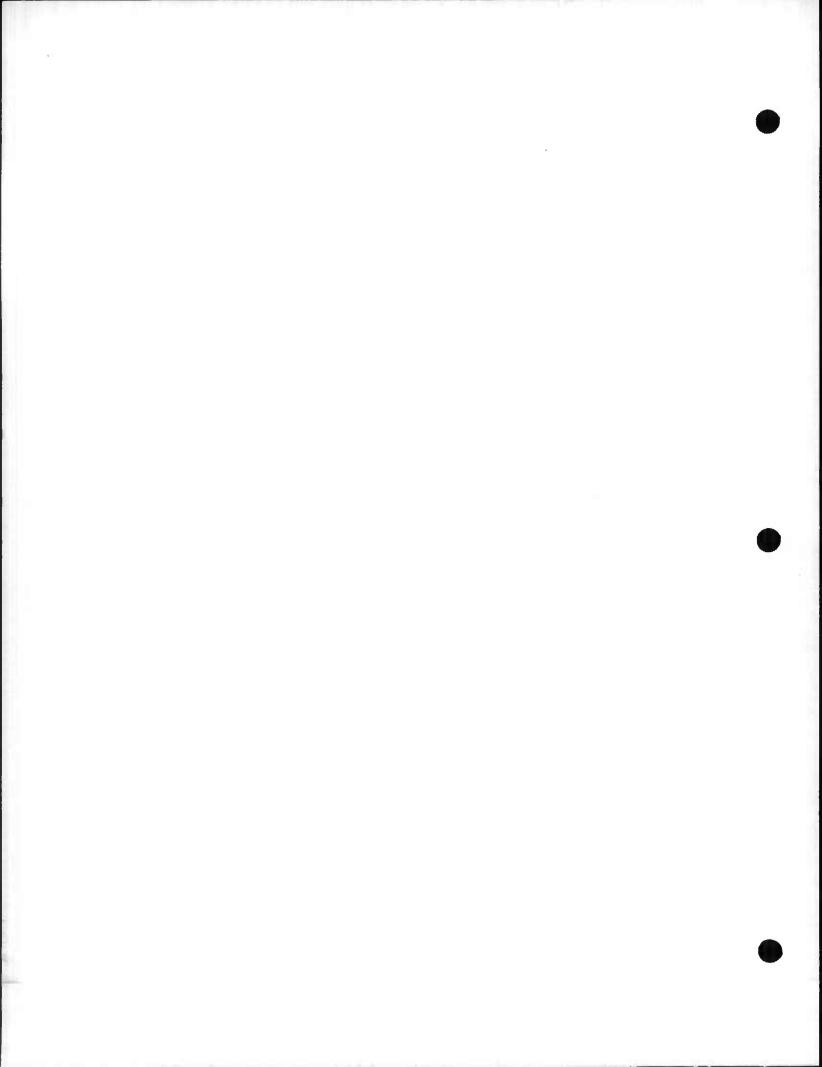
Street,

Baltimore Maryland

BALTIMORE, MARYLAND 21215-0020	burs after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should into the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	redical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygliene prior to burlal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

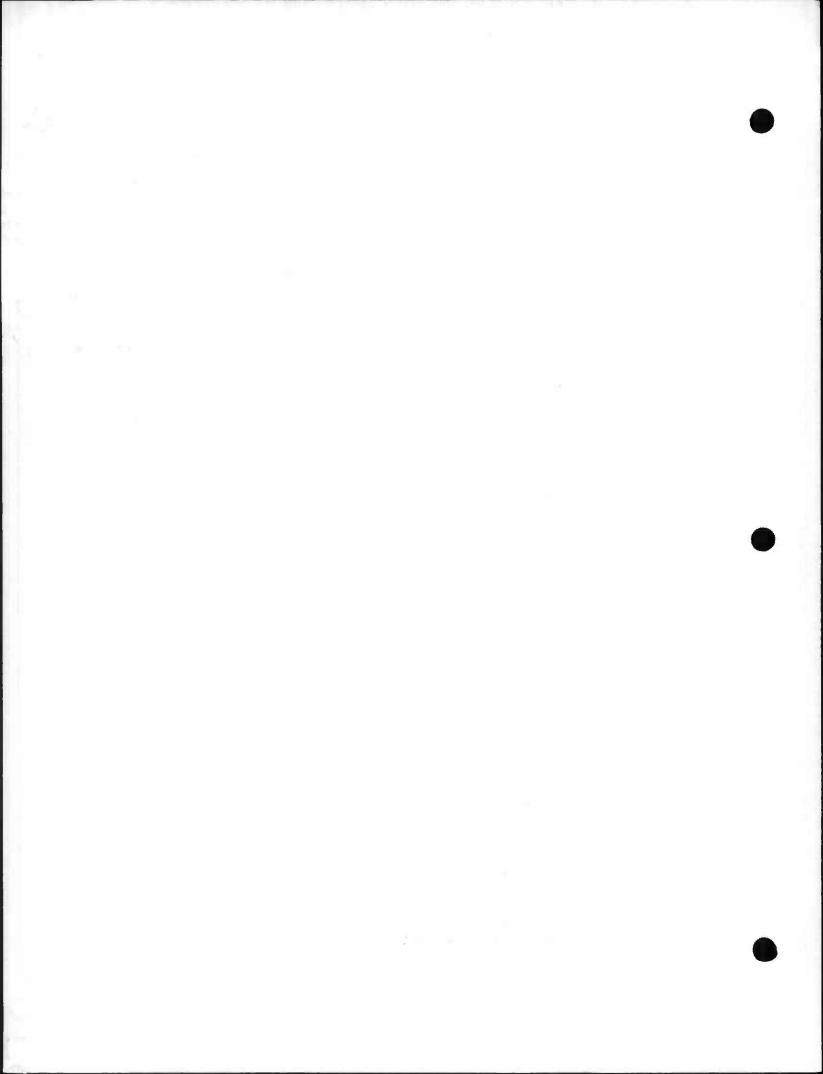
FOR STATE

	REGISTRAR		CERTIF	CALE OF	DEATH	H	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF I	DEATH DAY	YEAR	3. TIME OF DEATH
		SAMOND WRIC	JHT			June	7.	1995	9:10 AM
	4. SOCIAL SECURITY NUMBER 5	5. SEX 8. AGE (	In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E		0. BIRT	THPLACE (State or Foreign
	227-40-3334	1 □ M 2 X F 8	5 YRS.	MONTHS DAYS	HOURS MIN.			909 V	irginia
	9e. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF D			9c. COUNTY OF	
OB	Meridian - Frankl	in Woods		Ralt	imore			Bal-	timore
5	RESIDENCE OF DECEDENT	110000						Dai	THIDTE
DIRECTOR		J.,		Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?
		imore		Perry Ha					1 TYES 2 NO
NA I	10e. STREET AND NUMBER			10	Of. ZIP CODE		1	0g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	9327 Perglen Rd.				21230			USA	
5	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DE	CENDENT OF HISPA pecify Cuben, Mexic	NIC ORIGIN? (Se	pecify Yee or	No- 14. RA	CE — American Indian, ick, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			S 2 X NO Speci		i, areas		ocity:
	15. DECEDENT'S EDUCAT	TION	PEOPPEARIO			T			White
COMPLETED	(Specify only highest grade co.	ompleted)	16a. DECEDENT'S (Give kind of w life. Do NOT us	vork done during m	ION lost of working	16b, KIN	D OF BUSINE	ESS/INDUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		maker			Home		
N C	17. FATHER'S NAME (First, Middle, Last)		IMIL	IKIKET	To Marilenia M	THE PERSON NAMED			
		right			18. MOTHER'S N.	AME (First, Middle Bett			
BE	190. INFORMANT'S NAME (Type/Print)	Igne	T 405 MAILING	-220000 (0)				-1	
6	Ann C. Ansel				and Number or Rural				
	20a. METHOD OF DISPOSITION	Loop			Rd., Per				
	1 № Buriel 2 ☐ Cremation 3 № Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State cem	PLACE AND DATE Of the stery, crematory or other stery.	ther place)		DATE		TION — City or	
	21. SIGNATURE OF FINERAL SERVICE LICEN	UCC C	omers Roc	ck Cemet	tery 6-1	1-95	_ Come	ers Roc	ck, Virginia
	14.10 /	201 1	1				TT Fu	neral F	Home, P.A.
l.	system a	Mugli	7	1317	Cokesbur	ry Rd.,	Abino	gdon, N	4d. 21009
	23. PART i. Enter the diseesea, or con ahock, or heart failure. Lis	mplications that ceused	the deeth. Do n	ot enter the m	ode of dying, au	ch aa cerdiac	or reepirate	ory arreat,	Approximate
	IMMEDIATE CAUSE (Final	at Office parage on ea		3		. 1			Onset and Death
	disease or condition resulting in death)	alzher	Men	tupe	Denre	noted			lours
- 1	The state of the s	DUE TO (OR AS A	CONSEQUENCE OF	7:	400				
Z	b.								
TIC	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
2	cause. Enter UNDERLYING CAUSE (Disease or injury								
비	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ን:					
CERTIFICATION	d.								
- 1	PART ii. Other aignificant conditions	contributing to deeth be	ut not resulting in	n the underlyin	ng cause given in	Pert i. 24a	. WAS AN AU	TOPSY 24	b. WERE AUTOPSY FINDINGS
CAL	PART II. Other algnificant conditions of	1 7 - 1	ut not resulting I	n the underlyin	ng cause given in		PERFORME	D?	Nb. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	congestive hea	1 faile	re					D?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Σ	congestive hea atheroscleriti	c Cardio	re rascula	r duse	ase	10	PERFORME	D?	AMILABLE PRIOR TO COMPLETION OF CAUSE
Σ	atheroscleroti	c Cardio	rascula F DEATH YE	r duse	UNCERTAL	10	PERFORME	D?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Σ	CONGULTIVE hea ATHERS SERVED DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	Cardio N BUTE TO CAUSE OF	rascula F DEATH YE	S NO D	UNCERTAI	10	PERFORME YES 2	D?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Σ	CONGULTIVE hea ATHERS SERVED DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	BUTE TO CAUSE OF	F DEATH YE 26. PLACE OF DEAT	S NO DH (Check only one OTHER:	UNCERTAL  Discontinuo 5 - Reeldence	1 C	PERFORME YES 2	NO	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1  27. MANNER OF DEATH  1   Netural 5   Pending	Cardio N BUTE TO CAUSE OF	rascula F DEATH YE	S NO D'H (Check only one OTHER: 45 Nursing Hore Por URY W	UNCERTAL  UNCERTAL  UNCERTAL  UNITY AT  ORK?	1 C	PERFORME YES 2	D?	AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1  27. MANNER OF DEATH  1   Natural 5   Pending Investigation	BUTE TO CAUSE OF  HOSPITAL:    Inpetient 2   ER/Output  (Month, Day, Year)	F DEATH YE 26. PLACE OF DEAT atlent 3 DOA 29b. TIME	S NO NO NOTHER:  NOTHER:  Nursing Hore  OTHER:  WM Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  OTHER	UNCERTAL  UNCERTAL  UNCERTAL  UNITY AT  ORK?  YES 2 NO	6 Other (Sp	PERFORME YES 200	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MI	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1  27. MANNER OF DEATH  1   Netural 5   Pending	BUTE TO CAUSE OF	F DEATH YE 26. PLACE OF DEAT stient 3 DOA 26b. TIME	S NO NO NOTHER:  NOTHER:  Nursing Hore  OTHER:  WM Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  Nursing Hore  OTHER:  OTHER	UNCERTAL  UNCERTAL  UNCERTAL  UNITY AT  ORK?  YES 2 NO	6 Other (Sp	PERFORME  YES 25	NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	BUTE TO CAUSE OF  HOSPITAL:    Inpetient 2   ERVOUTE    280. DATE OF INJURY (Month, Day, Year)  280. PLACE OF INJURY building, stc. (Speci	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 20b. TIME inju	S NO NO NOTHER: 4" Nursing Hor Way M 1   street, factory, office	UNCERTAI  UNCERTAI  UNCERTAI  UNTY AT  ORK?  YES 2 NO	6 Other (Sp. 28d. DESCRIE	PERFORME YES 2	JRY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  1 Natural 2 Accident Investigation 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only)  1 CERTIFYING PHYSICIA	BUTE TO CAUSE OF  HOSPITAL:    Inpetient 2   ER/Outp  260. DATE OF INJURY (Month, Day, Year)  260. PLACE OF INJURY building, atc. (Special Control of the best of my knowledge)	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 29b. TIME injty  — Al home, ferm, st	S NO NO NOTHER:  4 Nursing Hor EOF 28c. IN. W. M 1  street, factory, officed at the lime, date	UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  NO  ORK?  YES 2 NO  ce  e end place, end dur	6 Other (Sp 28d. DESCRIE 28f. LOCATIO) City or To	PERFORME  YES 2  ec/ly) BE HOW INJU  N (Street end wn, Stete)	NO  NO  NO  Number or Rural  r ee stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,
ED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   Yes 2   NO   1  27. MANNER OF DEATH 1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined  20. CERTIFIER (Check only One) 2   MEDICAL EXAMINER:	BUTE TO CAUSE OF  HOSPITAL:    Inpetient 2   ER/Outp  260. DATE OF INJURY (Month, Day, Year)  260. PLACE OF INJURY building, atc. (Special Control of the best of my knowledge)	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 29b. TIME injty  — Al home, ferm, st	S NO NO NOTHER:  4 Nursing Hor EOF 28c. IN. W. M 1  street, factory, officed at the lime, date	UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  NO  ORK?  YES 2 NO  ce  e end place, end dur	6 Other (Sp 28d. DESCRIE 28f. LOCATIO) City or To	PERFORME  YES 2  ec/ly) BE HOW INJU  N (Street end wn, Stete)	NO  NO  NO  Number or Rural  r ee stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,
COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  1 Natural 2 Accident Investigation 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only)  1 CERTIFYING PHYSICIA	BUTE TO CAUSE OF  HOSPITAL:    Inpetient 2   ER/Outp  260. DATE OF INJURY (Month, Day, Year)  260. PLACE OF INJURY building, atc. (Special Control of the best of my knowledge)	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 29b. TIME injty  — Al home, ferm, st	S NO NO NOTHER:  4 Nursing Hor EOF 28c. IN. W. M 1  street, factory, officed at the lime, date	UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  UNCERTAI  NO  ORK?  YES 2 NO  ce  e end place, end dur	6 Other (Sp. 28d. DESCRIE 28f. LOCATION City or To	PERFORME YES 2  ecity)  BE HOW INJU  N (Street and wn, State)  o end menner place, end de	Number or Rural r ee stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,
BE COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO   1  27. MANNER OF DEATH 1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined  20	BUTE TO CAUSE OF T	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 28b. Time invited the stient of the stient o	S NO H (Check only one OTHER: 4 Nursing Hor EOF URY M 1 1 Interest, factory, officed at the time, date n, in my opinion, d	UNCERTAI  UNCERTAI  The solution of the soluti	6 Other (Sp. 28d. DESCRIE 28f. LOCATION City or To	PERFORME YES 2  ecity)  BE HOW INJU  N (Street and wn, State)  o end menner place, end de	Number or Rural r ee stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  I Route Number,
COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO   1  27. MANNER OF DEATH 1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined 4   Homicide 6   Could not be determined  290. CERTIFIER (Check only One) 2   MEDICAL EXAMINER:  20b. SIGNATURE AND TITLE OF CENTIFIER  30. NAME AND ADDRESS OF PERSON WHO CO	BUTE TO CAUSE OF  HOSPITAL:    Inpatient 2   ERVOUTPI   28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, stc. (Special Place of exemination)  AN: To the best of my knowledge of exemination  COMPLETED CAUSE OF DEA	F DEATH YE 26. PLACE OF DEAT stient 3 DOA 29b. TIME injuly All home, ferm, s edge, death occurre a end/or investigation	S NO  N (Check only one OTHER:  Number of Sec. IN WY M 1   street, factory, office and at the lime, date n, in my opinion, office Print)	UNCERTAI  TORK?  YES 2 NO  To e end place, end during death occurred at the course of	6 Other (Sp. 28d. DESCRIE 28f. LOCATION City or To	PERFORME YES 2V  ec/ly) BE HOW INJU N (Street end wn, Stete) ) end menner place, end di	NO  NO  NUMBER OF RURAL  T ee stated.  Itue to the cause  9d. DATE SIGNE	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,  (e) end menner se stated.
BE COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	BUTE TO CAUSE OF THE PROPERTY	F DEATH YE 28. PLACE OF DEAT atlent 3 DOA 29b. Time in Al home, ferm, s' edge, death occurre a end/or investigation ATH (ITEM 27) (Type, 95248	S NO  N (Check only one OTHER:  Number of Sec. IN WY M 1   street, factory, office and at the lime, date n, in my opinion, office Print)	UNCERTAI  UNCERTAI  The solution of the soluti	6 Other (Sp. 28d. DESCRIE 28f. LOCATION City or To	PERFORME YES 2V  ec/ly) BE HOW INJU N (Street end wn, Stete) ) end menner place, end di	NO  NO  NUMBER OF RURAL  T ee stated.  Itue to the cause  9d. DATE SIGNE	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,  (e) end menner se stated.
BE COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO   1  27. MANNER OF DEATH 1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined  20	BUTE TO CAUSE OF  HOSPITAL:    Inpatient 2   ERVOUTPI   28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, stc. (Special Place of exemination)  AN: To the best of my knowledge of exemination  COMPLETED CAUSE OF DEA	F DEATH YE 20. PLACE OF DEAT stient 3 DOA 28b. Time invited from the stient of the sti	S NO  N (Check only one OTHER:  Number of Sec. IN WY M 1   street, factory, office and at the lime, date n, in my opinion, office Print)	UNCERTAI  TORK?  YES 2 NO  To e end place, end during death occurred at the course of	6 Other (Sp. 28d. DESCRIE 28f. LOCATION City or To	PERFORME YES 2V  ec/ly) BE HOW INJU N (Street end wn, Stete) ) end menner place, end di	NO  NO  NUMBER OF RURAL  T ee stated.  Itue to the cause  9d. DATE SIGNE	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1 YES 2 NO  1 Route Number,  (e) end menner se stated.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)  ROBERT L. WILSON III		2. DATE OF DEATH DAY 5 28 1	3. TIME OF DEATH 11:17p M						
		UNDER 1 YEAR IF UNDER 24 HRS.  NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-27-1951	8. BIRTHPLACE (State or Foreign County) MARYLAND						
стоя	204 MAIN ST.	MARDELA SF		OUNTY OF DEATH						
DIRECT	1 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION MAD DET A CORTING									
FUNERAL	100. STREET AND NUMBER 204 MAIN ST	101. ZIP CODE 21837	10g. C	1 YES 2 NO CITIZEN OF WHAT COUNTRY?  U.S.A.						
BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			14. RACE — American indian, Black, White, atc. Specify: WHITE						
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (6-12)  College (1-4 or 5+)  ACCOUN	done during most of working blired.)	166. KIND OF BUSINESS/							
E COMPL	17. FATHER'S NAME (First, Middle, Last)  ROBERT L. WILSON	18. MOTHER'S NA	ME (First, Middle, Maiden Surname E WAGNER							
TO BI		DRESS (Street and Number or Rural MAIN ST . MAR								
	20s. METHOD OF DISPOSITION  1\( \) Burlel 2 \( \) Cremation 3 \( \) Removal from State  4 \( \) Donation 5 \( \) Other (Specify)  20b. PLACE AND DATE OF Camelory, crematory or other MARDELA	CEMETERY	5-30 MARD	- City or Town, State OELA, MD.						
	22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD									
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST  List only one ceuse on each line.  SETURE OF TAKE	MONIA	ii aa calulee or reapiratory	Approximate interval Between Onset and Death						
EDICAL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 244. WAS AN AUTOPSY 24									
HAN: W	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL	DEATH YES No		1 YES 2 NO						
PHYSICI	1   YES 2   5-NO   1   Inpetient 2   ER/Outpetient 3   DOA 4  27. MANNER OF DEATH   26s. DATE OF INJURY   26b. TIME O		6 Other (Specify) 26d. DESCRIBE HOW INJURY (	OCCURED						
D BY	1 Metural 5 Pending (Month, Day, Year) INJURY 2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, stree building, atc. (Specify)	M 1 YES 2 NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETE	29a. CERTIFIER (Check only one)  29 MEDICAL EXAMINED On the best of my knowledge, death occurred a		to the cause(e) end menner as							
BE	2 MEDICAL EXAMINER: On the besis of examination and/or investigation, I  29b_SIGNATURE AND TITLE OF CERTIFIER  August 10 Proceedings 197	29c. LICENSE NU		DATE SIGNED (Month, Day, Year)						
TO	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Pri	BURY RAD	- 2/8	07 1						
	31. DATE FILED (Month, Day, Year)  22. ANGESTRAP'S SIGNATURE  24. MAY 3 () 1995			1 1 1 1						



BALTIMORE, MARYLAND 21215-0020

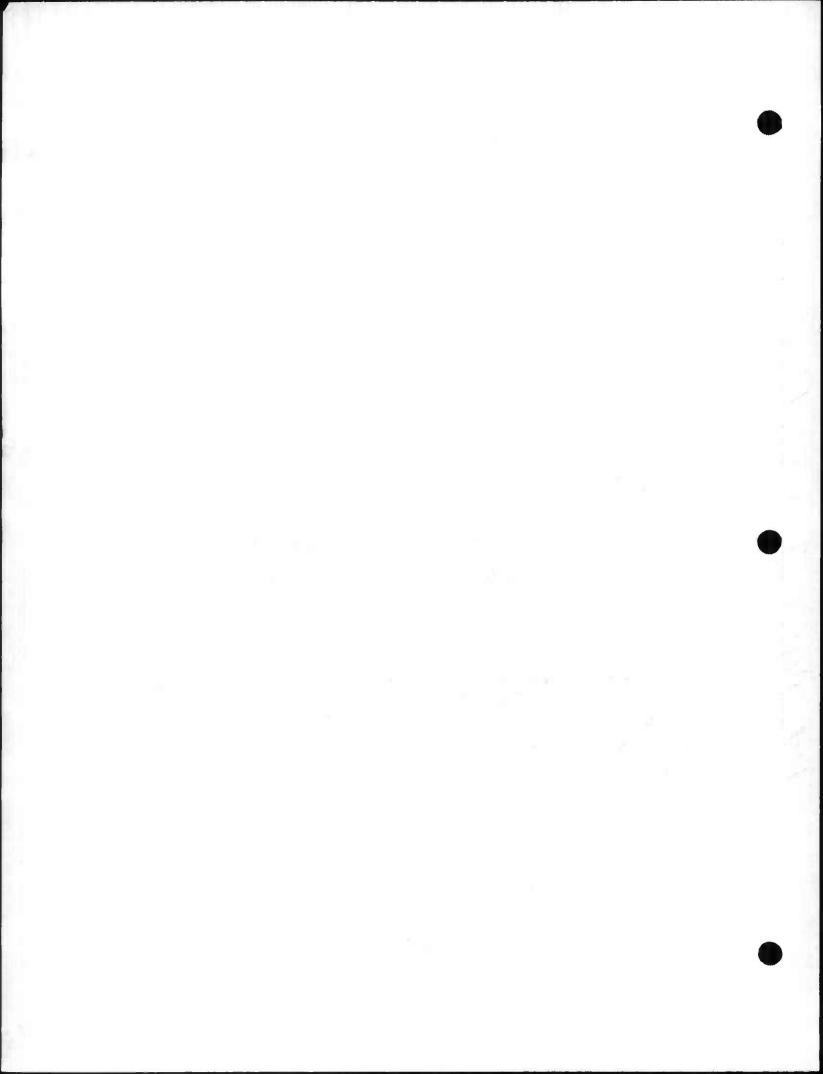
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital by the desired by the stending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG. NO	).		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		T	3. TIME OF DEATH
	Florence E. Walker	d				A CONTRACT OF THE PARTY OF THE	AY	45	1057:
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH			1000
	222 12 71-2	1 □ M 2 🕅 F	86 YRS.	MONTHS DA		(Month Day Year)		Country)	
			00 ms.			July 15,	1908	Dela	aware
l m	9e. FACILITY NAME (If not institution, give stre	let end number)		9b. CITY, TOV	N OR LOCATION OF D	EATH	9c. COUN	TY OF DE	ATH
DIRECTOR	Union Hospital			E1kt	on		Cec:	il Co	ounty
<u>N</u>	10e. STATE 10b. COUNTY		40.00						
=		7		Y, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?
		Castle	Ne	wark					1 TES 2 NO
₹ X	10a. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZ	ZEN OF WI	IAT COUNTRY?
Ü	1624 Pulaski Highw	ay			19702		Uni	ted S	States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S.ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	n or No—	14. BACE	- American Indien,
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 D	, specify Cuben, Mexica YES 2 1 NO Specif	in, Puerto Ricen, etc.)		Specify	White, etc.
	3 24 Widowed 4 Divorced								White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	ATION ompleted)	16e. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	SINESS/IND	USTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	most of working				
₽ P	8		Homemak	er		Domesti	ic		
ō	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surnamei		
	Harry B. Walker, S	Sr.				Mae Shaffer			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS /Stre		Route Number, City or Tow		Control	
2	Ronald E. Walker					ark, Delawa			
	20at METHOD OF DISPOSITION	100						19711	
	1 Paurial 2 Cremetion 3 Remov	rai from State cen	PLACE AND DATE of the letery, crematory or o	OF DISPOSITION ther place)	(Name of	DATE 20c. LO	CATION 0	City or Tow	n, State
. 8	4 Donation 5 Other (Specify)	G	racelawn	Memor	ial Park	6/5/95 Wil	Lming	ton,	Delaware
1 8	21. SIGNATURE	NSEE /	1.	Ro Ro	end address of fa	ones & Foar	d. Tr	10.	
	The house	7 (1	nodia.	12	West Mai	n St Nor	rark	Dola	ware 19711
	23. PART I. Enter the diseases, or co	mplications that caused	the deeth. Do r	not enter the	mode of dylng auc	h as cardiac or man	retory er	DETa	
	23. PART I. Enter the diseases, or co- ahock, or heart failure. Li	st only one cause on a	ach ligie.		and or aying, add	ii aa ooralaa or reapi	natory arre	amr.	Approximata Interval Batween
	IMMEDIATE CAUSE (Final disease or condition	000-	12.020	404 - 0	coci	~			Onset and Death
	resulting in death) a.	Cherry	v rejer	1114	Sepsi				
		DUE TO (DR AS A	CONSEDUENCE OF	F): \( \)		414	1		
N N	Sequentially list conditions, b.	COPUN	preui	NOV 14	~ cryo	anism u	ner	now	4.
CERTIFICATION	if any, leading to immediate	DUE TO (OR AS	CONSEDUENCE DI	F):					
2	CAUSE (Disease or Injury								
쁜	that initiated events	DUE TO (DR AS A	CONSEQUENCE OF	F):					
H	resulting in death) LAST								
	PART In Other algoliticent conditions	contribution to doub b							
CAL	Variate alica	contributing to dante of	/		ing ceuse givan in	Part I. 24s. WAS AN PERFOR		1	VERE AUTOPSY FINDINGS
ă	10000 S(XIX	age or	bone	, pe	ripreso	1 U YES 2	□ Mer		COMPLETION OF CAUSE OF DEATH?
ME	VOISCULOR	ON SCOISE			,		,		TYES 2 NO
	DID TOBACCO USE CONTRI	<b>BUTE TO CAUSE O</b>	F DEATH YE	S NO	W UNCERTAIN	v 🗆			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT						
S		HOSPITAL:	atlent 3 DOA	OTHER:	ome 5 Residence	4			
主	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIM		INJURY AT	28d. DESCRIBE HOW II	HILBY OCC	UDED	
0	1 Natural 5 Pending	(Month, Day, Year)		URY	WORK?	EGG. DESCRIBE NOW II	NON1 OCC	UNED	
B	2 Accident Investigation	28s. PLACE OF INJURY	- At home form of		1/0				
8	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	— At nome, term, sify)	rreet, rectory, o	mice	28f. LOCATION (Street a City or Town, Stete)	and Number of	or Rural Rou	ite Number,
1 1 1			-						
립	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	AN: To the best of my know	ledge, death occum	d at the time, d	ate and place, end due	to the cause(s) and man	iner ea state	d.	
8	29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner ea stated.  2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner examination.							and manner es stated.	
0	29b. SIGNATURE AND DILE, OF CERTIFIER	y. 'es			29c. LICENSE NUN				
ᆱ	(HAMMANAP)	and			7) // -		ZYG. DATE	STUNED (A	Nonth, Day, Year)
임	38. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH //TEM 27 /3	Dried)	1451	55	6	12/	75
	101 100 1	60	LIC MILITARY	0//	5101	te 2A.	6	11.	1 4 1
	31. DATE FILED (Month, Day, Year)		118 100	Etho	J+ 21117	te 24.	-	KTB.	N.Md
	JUN 2 1995	July d'aude	ATURE J. II						
	3014 8 1333	James ar notas	ev. Manager						



1 -	FOR STATE REGISTRAR

	REGISTRAR		CER	TIFIC	ATE O	F DEATH	F	REG. NO.			
8	1. DECEDENT'S NAME (First, Middle, Last) RAYMOND	WILLI			W	RIGHT, SR	2. DATE OF	27 DAY	1995	J. 3.	TIME OF DEATH 2:48A
	4. SOCIAL SECURITY NUMBER 219-76-0864	1 XM 2 F	AGE (In yrs. lest birt		UNDER 1 YEAR		7. DATE OF (Month, De Feb.	BIRTH 26, 1	C	ountry)	ACE (State or Foreign
FOR	9a. FACILITY NAME (If not institution, give st RT 213 1/4 MIL	,	RT 273	96	E1kt	OR LOCATION OF O	EATH		9c. COUNTY OF DEATH CECIL		
2	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	,	140	- OITY TO	OWN OR LOC	ATION					
FUNERAL DIRECTOR	Maryland Cec:	_			th Ea	st			10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
VERA	7 Yorktown Court					21901			U.S.		T COUNTRY?
В	11. MARITAL STATUS 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1   IF YES, GIVE WAR	YES 2 X NO		If yes,	ECENDENT OF HISPAI specify Cuben, Maxica ES 2 X NO Specif	n, Puerto Rica	ipecify Yea o n, etc.)		ACE — Black, W Specify:	American Indian, hita, atc. White
	15. OECEDENT'S EDUC	CATION	16a. DECEO	ENT'S USU	JAL OCCUPA	TION	16b, KIP	ND OF BUSI	NESS/INDUSTR	(Y	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 7	College (1-4 or 5+)	(Give ki	ind of work NOT use re	done during tired.)	most of working		tomot			
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME /First Allelel	No Administra Co			
BE C	Tod E. Schenck						Marl	ene J	. Wrig		
2	19a. INFORMANT'S NAME (Type/Print) Marlene J. Schen	nck	19b. m/	York	town	t and Number or Rural Court - N	orth E	ast,	State, Zip Code MD 21	901	
	20a. METHOD OF DISPOSITION  1  Burlal 2  Cremetion 3  Remote	oval from State	20b. PLACE AND I cemetery, cremeto R. A. F	ry or other	place)	Name of Ompany	5 <sup>™</sup> 360		t Ches		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND ADDRESS OF FACULTY HICKS Home for Funera 103 West Stockton Str					als, P.A.		
_	Donald	2 He	iles		E.1	kton MD	21921	-5521			
	23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	Head	on aach lina.	urie	2S	ioda or dying, suc	n ss cardisc	or respira	nory srrest,		Approximets Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  b. DUE TO (OR AS A CONSEQUENCE OF):  c. OUE TO (OR AS A CONSEQUENCE OF):										
H	resulting in death) LAST	l									
	PART II. Other significant conditions	a contribution to de									
EDICAL	NATI II. Other significant conditions	commoding to da	ath out not resul	iting in tr	na undariyi	ng cause given in		PERFORM	ED?	CO OF	RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE DEATH?
Σ	DID TORACCO LICE CONTE	IDLITE TO CALL	E OF BEARI	1470		7			1	1 5	VES 2 NO
3	DID TOBACCO USE CONTR	IBUTE TO CAUS					1				
ਹੋ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF		THER:						
S	1X) YES 2 □ NO	1 Inpetient 2 I EF	NOutpatient 3 🗆 D	DOA 4	Nursing Ho	me 5 🗆 Raaldence	6X Other (Sp	pecify) RC	DADWAY	Z .	
BY PHYSICIAN:	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJ (Month, Day,	Vear) -95 0	b. TIME OF INJURY	V	VORK?  YES 2 NO	Orive	BE HOW INJ	- Single refichle		
	3 Suicide 8 Could not be determined	IJURY — At home, 1 (Specify) ROAd			ice		wn, State)	and Number or Rural Route Number,			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 1 X MEDICAL EXAMINES	CIAN: To the best of my	knowledge, death o	occurred at	the time, de	ta and place, and due	to the cause(e	) and menne	er as stated,		
8	2 MEDICAL EXAMINES	-01	THE PERSON NAMED IN COLUMN	yeuon, In	my opinion.	ownin occured at the	time, date and	place, and	ava to the cau	re(e) an	a menner se stated.
8	295. SIGNATURE AND TITLE OF CENTURES	· GOL	(			O . C . N	ieer 1.E.		MAY	27	, 1995
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	DE DEATH (ITEM 27)	NN S	TREE	T, BALTI	MORE	, MAI	RYLANI	) 2	1201.
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE								
	MAY 3 1 1995 /	Li Steveles	Radall								

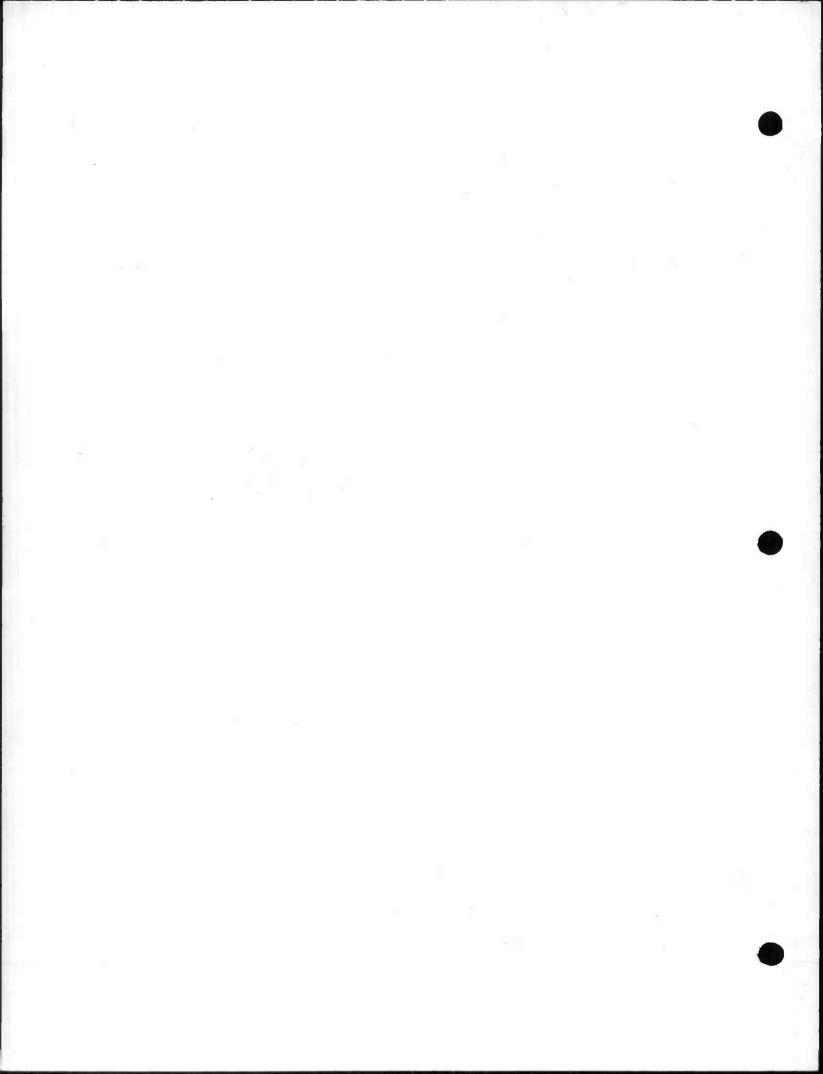
TO THE FUNETAL DIRECTOR: After this certificate be and certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

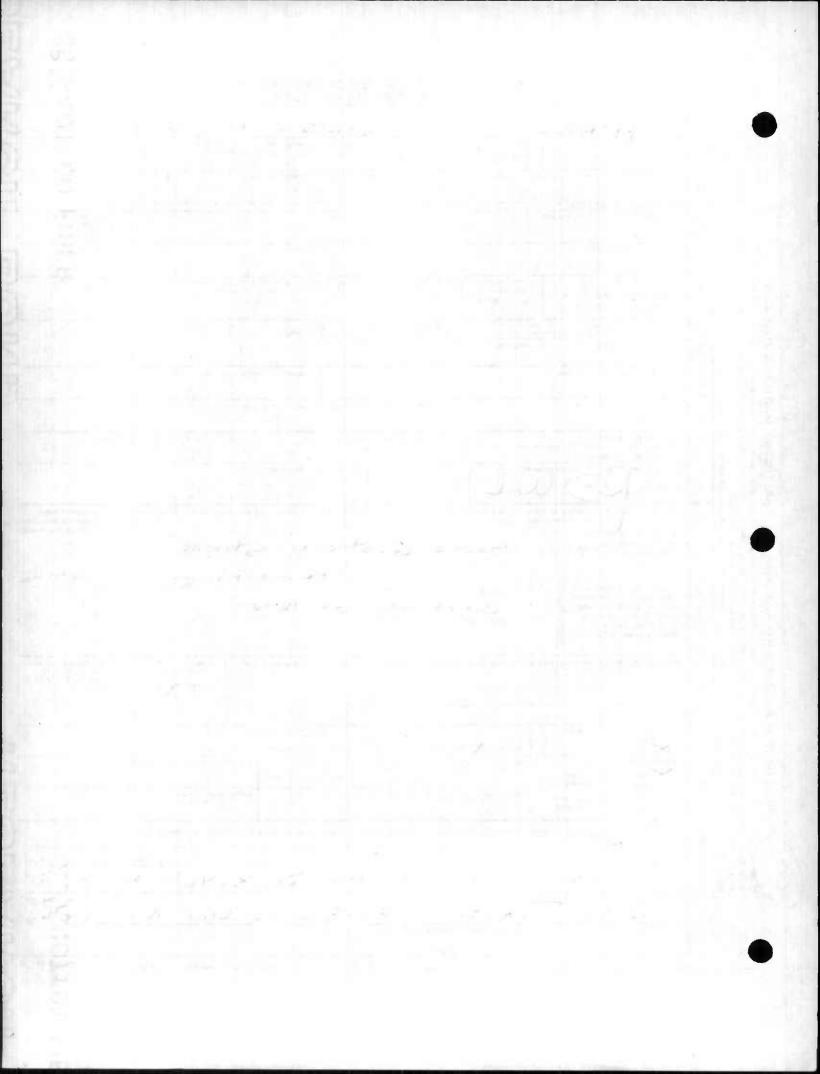
	REGISTRAR		CERTIF	ICATE OF D	EATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
1	Shirle	1 Mae Watkins	3			May 30,	1995 YEA	5:50A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR IF	UNDER 24 HRS.	7. DATE OF BIRTH	8, Bil	RTHPLACE (State or Foreign
	578-44-8128	1 M 2 X F	58 YRS.	MONTHS DAYS HO	URS MIN.	July 5, 19	Co	untry)
	Se. FACILITY NAME (If not institution, give s	treet and number)	30	9b. CITY, TOWN OR L			9c. COUNTY O	shington, DC
œ	Docotr's Communit				OCKNOW OF DEA	NIN .		
16	RESIDENCE OF DECEDENT	y nospital		Lanham			Prince	George's
DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCATION				10d. INSIDE CITY
등	Maryland Princ	e George's	Hys	ttsville				LIMITS?
	10a. STREET AND NUMBER	000160	11196	10f. ZIP	0005			1 X YES 2 NO
FUNERAL	4103 Roanoke Road	1		20				F WHAT COUNTRY?
N.	11. MARITAL STATUS				02		U.S.A.	
교	1 Never Merried 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS DECENO	ENT OF HISPANI Cuban, Mexican	C ORIGIN? (Specify Yes, Puerto Rican, etc.)	or No- 14. R/	ACE — American Indian, lack, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		NO Specify:		Sp	White
	15. DECEDENT'S EDU	CATION						
COMPLETED	(Specify only highest grade	completed)		Work done during most of	working	16b. KIND OF BUS	SINESS/INDUSTRY	1
뿌	Elementary/Secondary (0-12)	College (1-4 or 5+)		·				
\$	12		Data Pr	ocessor			vernmen	t
8	17. FATHER'S NAME (First, Middle, Last)					E (First, Middle, Maiden	Sumame)	
H	Charles Woodrow W	atkins		F	Elsie Ma	ay Sherry		
0	19a, INFORMANT'S NAME (Type/Print)			ADDRESS (Street and N				
-	Constance Birch		4103	Roanoke Ro	ad, Hya	attsville,	Maryla	nd 20782
	20e. METHOD OF DISPOSITION 1 Duriel 2 X Cremetion 3 Rem	20t	. PLACE AND DATE	OF DISPOSITION (Name o			CATION — City or	
	4 Donation 5 Other (Specify)	Svel from State Cen	netery, crematory or o etropoli	therplace) tan Cremat	ory 05/	31/95 110	vandria	, Virginia
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	A	22. NAME AND A	DORESS OF FACI	ILITY		
	De la la	1 BOMI	1 _	Francis	Gasch'	s Sons Fu	neral H	ome, P.A.
	necrees	ti sell		4739 Ba	ltimore	e Ave., Hy	attsvil	le, MD 20781
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications that caused List only one cause on a	d the deeth. Do i lach lina.	not enter the mode of	of dying, such	as cardiec or respi	ratory screet,	Approximate interval Between
	IMMEDIATE CAUSE (Final	0	0 1				19	Onset and Death
	disease or condition resulting in death)	. Kes bireto	ic Tail	lowe				5/12 - 5/2
	, odding at odding	DUE TO (OR AS /	CONSEQUENCE O	F): //				12 3 1/20
z		. Metastat	ic Ca	Cours				4/90
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):				177
8	cause. Enter UNDERLYING	. Huse te	111					1980
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				1770
듄	resulting in death) LAST							
뜅		2,						
A	PART ii. Other significent condition	a contributing to death b	out not resulting	in the underlying ca	use given in P	Pert i. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
DICAL						1 YES 2		COMPLETION OF CAUSE
ME								OF DEATH?
-	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YE	SUNOUI	INCERTAIN			1  123 2
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA		TITCERIAII			
SC	EXAMINER?	HQSPITAL:		OTHER:				
ξ	27. MANNER OF DEATH	28e. DATE OF INJURY		4 Nursing Home 5				
	Natural 5 Pending	(Month, Day, Year)	28b. TIM	URY WORK?		28d. DESCRIBE HOW II	NJURY OCCURED	
Β¥	2 Accident Investigation			M 1 YES	2 NO			
	3 Suicide 8 Could not be	28s. PLACE OF INJURY building, atc. (Spec	— At home, farm, i	street, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Run	al Route Number,
COMPLETED	4 Homicide determined					City Ci TOWN, Clercy		
12	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	ledge, death occurs	ed at the time date and	nince and due to	the cause/s) and man		
×		R: On the basis of exemination						ofe) and manner on stated
8	29b. SIGNATURE AND TITLE OF CERTIFIER						to the cetts	etal and manner as stated.
BE	296. SIGNATUME AND TITLE OF CENTIFIER	n POOL	HIKIAS	1/. 290	LICENSE NUMB			ED (Month, Day, Year)
0	1,000				MD34722		> 5-	-30-91
- 1	30. NAME AND ADORESS OF PERSON WH				0			
4	Dr. Vicken Pooch			Koad Suit	e 3 Bla	densburg,	MD 20:	710
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE					
	JUN 01 1995 YW	in altivation hard	all l					



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

NECIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	on, or removal.	he medical examiner must be notified at once.
TO THE HISPITAL CHARTENDING PAYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4. SOCIAL SECURITY NUMBER 238 70 5513	ACE					
4. SOCIAL SECURITY NUMBER 238 70 5513				2. DATE OF DEATH	YEAR	3. TIME OF DEATH
238 70 5513	E CEV BAG	5 00 000 000 000 000 000	NOSTAL	1 2	77	2 . 0 . 14.
		MOI	UNDER 1 YEAR F UNDER 24 HRS. HTHS DAYS HOURS MIN.	7. DATE OF BIFTIN (Month, Day, Year) AUG 19 19	Counti	PLACE (State or Foreign
	lon, give street and number)	U	CITY, TOWN OR LOCATION OF D		c. COUNTY OF D	
	ADVENTIST HO		TAKOMA PARK		MONTGO	
MD .	MONTGOMERY		OWN DR LOCATION			10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER	MONIGOMERI	TAK	OMA PARK	1		1 X YES 2 NO
ACCEPTED TO THE STATE OF THE ST	ER AVENUE A	PT.2	20912	10		VHAT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Vec or	USA No. 1 14 BACI	E — American Indian.
1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 YE	S 2 XNO	If yes, specify Cuban, Maxic 1 ☐ YES 2 X NO Speci	en, Puerto Ricen, etc.)	Black	LACK
	NT'S EDUCATION heat grade completed)	16a. DECEDENT'S USL	JAL OCCUPATION	16b. KIND OF BUSINE		
Elementary/Secondary (0-12)	College (1-4 or 8+)	Hite. Do NOT use re	done during most of working lired.)	FED. G	OVT.	
17. FATHER'S NAME (First, Middle,	Lest)		18, MOTHER'S N	AME (First, Middle, Maiden Sun	name)	
SHANK WAT				CILLIA JOH		
19a. INFORMANT'S NAME (Type/F	Print)	19b. MAILING AD	DRESS (Street and Number or Rural			
MAGGIE SHE	LLEY	8503 F	LOWER AVE,#	2 TAKOMA P.	ARK, M	ID. 20912
20a. METHOD OF DISPOSITION		06. PLACEAND DATE OF D		DATE 20c. LOCAT	ION — City or To	rwn, State
4 Donation 5 Other (Spe	clly)	FOREST HI	LL CEM. 5/	29/95 CLAY	TON, N	I.C.
21. SIGNATURE OF PUNERAL SE	SINICE LICENSEE		22. NAME AND ADDRESS OF FOUNDATION F.	ACILITY		
DE NO	). With			ST., N. W	2001	0
Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	S A CONSEQUENCE OF):  S A CONSEQUENCE OF):  S A CONSEQUENCE OF):	of Iwe	a pool		244
PART II. Other algorificant of	d.	but not resulting in ti	he underlying cause given in	Part I. 24s, WAS AN AUT	TOPSY 24b	WERE AUTOPSY FINDINGS
				PERFORME 1 VES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
25. WAS CASE REFERRED TO ME EXAMINER?			26. PLACE DF DEATH (C	heck only one)		
YES 2 NO	HOSPITAL:		THER:  Nursing Home 5  Residence	6 Other (Specify)		
27. MANNEB OF DEATH  1 Naturel 5 Pent	28a. DATE OF INJUR (Month, Day, Year stigation		F 28c, INJURY AT WORK? M 1 YES 2 ND	28d. DESCRIBE HOW INJU	JRY OCCURED	T. 18 13
3 Suicide 6 Coul	28e, PLACE OF INJU	RY — Al home, ferm, stree pecify)	rt, factory, office	26f. LOCATION (Street and City or Town, State)	Number or Rural i	Route Number,
29a. CERTIFIER 1 CERTIFY	NG PHYSICIAN: To the best of my kn					a) and manner es stated.
cool comp		0	29c. LICENSE NU	IMBER 21	9d. DATE SIGNED	(Month Dev Year)
cool ciny	CERTIFIER	V				(INOIAII, Day, Ioai)
0/10) DESMEDICAL 29b. SIGNATURE AND TITLE DF	and I wan	V.	DO DO	191286	ma	18-25-Mi
0/10) DESMEDICAL 29b. SIGNATURE AND TITLE DF	RESON WHO COMPLETED CAUSE OF		518 MIZ	19178 (N) 2ng	Acre	Petter



VA.FUNERAL SER

Approximata interval Between Onset and Daath

detached for use as the burial-transit permit. Pages 1, 2, 3 should urs after death. Page 6 may be retained by the hospital or attending physician,

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

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ector,		MUS
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THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

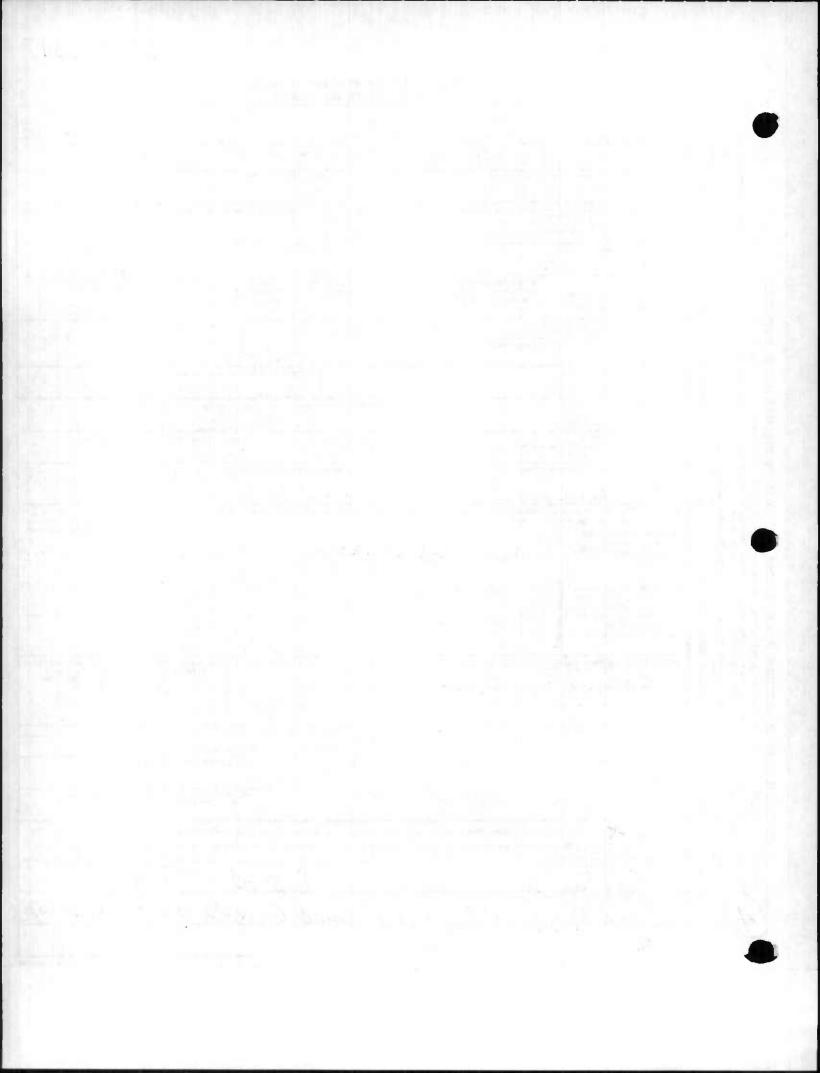
FOR 1 - STATE REGISTRAR		STATE OF M	MARYLANI	) / DEPAI CERTIF	RTMENT	OF H	EALTH DE A	AND 1	MENTA	L HYGIEN	_		
1. DECEDENT'S NAME (First,	Middle, Last)				10/11	- 01	DEA		2. DATE	OF DEATH			. TIME OF DEATH
MAGDALEN	E WII	LSON							MONT		EL C	YEAR 15	2:55 P
4. SOCIAL SECURITY NUMB		5. SEX	5. AGE (In yra	. leat birthday)	IF UNDER		IF UNDER	1 24 HRS.	7. DATE	OF BIRTH		6. BIRTHPI	LACE (State or Foreign
233-28-511	9	1 🗆 M 2 💢 F	7	YRS.	MONTHS	DAYB	HOURS	MIN.		h, Day, Year)	22	Country)	RGINIA
Se. FACILITY NAME (If not ins	attrution, give a	street and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH		Bc. COUN	ITY OF DEA	
GOLDEN OAK		RSING HO	OME		LA	URE	L				PRI	INCE	GEORGES
RESIDENCE OF DEC	10b. COUNT	Υ		10c. CI	TY, TOWN C	OR LOCA	TION					T,	Od. INSIDE CITY
MARYLAND	PRT	NCE GEOF	CES	1110	IVER								LIMITS?
10a. STREET AND NUMBER	LIVEI	VCL GEVI	1057	1 1/	TAFI		L ZIP COD	E	-		10a, CITI		AT COUNTRY?
5806 63RD	AVF.						207						
11. MARITAL STATUS	7,7,6	12. WAS DECEDEN			13.	WAS DEC			IIC ORIGII	17 (Specify Ye		S - A	- American Indian.
1 Never Married 2 3 Widowed 4 Divor		FORCES? 1		<b>_</b> /(•0			2 X NO			Rican, etc.)		Black.	White, atc.
	EDENT'S EDU		16a	DECEDENT'S	Work done	CCUPATE	ON out of world	na	168	. KIND OF BU	SINESS/IND	USTRY	
Elementary/Secondary (0-	-	College (1-4 or 8		RETIR	retired.)				ER.				
17. FATHER'S NAME (First, Mil	ddle, Lest)						18. MOT	HER'S NA	ME (First,	Middle, Malden	Surname)		
ROBERT	HOUS	SE					E	LIZA	BET	H WHI	TEHE	AD	
19a. INFORMANT'S NAME (Ty				196. MAILING	ADDRESS	Street (	and Number	r or Rural I	Route Num	ber, City or Tox	rn, State, Zip	Code)	
MORRIS W				5806	<b>63</b> R	DA	VE.	RIV	ERD	ALE T	ID - 20	737	
20a, METHOD OF DISPOSITION 1 X Buriel 2 □ Cremation	ON n 3 🗆 Rem	noval from Stata		CE AND DATE					DAT		CATION —	,	
4 Donation 5 Other	(Specify)		_   ""	URY					16-	3 RIC	HMON	DaVA	
21. SIGNATURE OF FUNERAL	. SERVICE LI	CENSEE	_		22.	NAME A	ND ADDRE	SS OF FA	CILITY C	ENTRA	L VA	-FUN	IERAL SE
1 She	lly	00	. el							ICHMO			
23. PART I. Enter the di	seases, or	complications the	t caused the	death. Do									Approximata
immediate cause (Fig.		List Dnly one cau	ise Dn aach	line.									Onset and Das
disease or condition resulting in death)	<b>→</b>	· Dan	-1 (0	II Ca	flin	am	G						5 Mani
reauting in death)	,	DUE TO	(OR AS A CON	BEQUENCE C	OF):	0.7							
		b											
Sequentially list condition if any, leading to immediate	liate	DUE TO	(OR AS A COR	SEQUENCE C	OF):								
Cause. Enter UNDERLY!! CAUSE (Disease or injur		c											
that initiated events resulting in death) LAS1		DUE 10	(OR AS A COP	ISEQUENCE C	OF):								
	-	d											-
PART II. Other algorification	nt condition	na contributing to	death but n	ot reauiting	in the ur	dariyin	g cause	given in	Part I.	24a. WAS AN			VERE AUTOPSY FINDING
Corong	n a	she Do	ese.						191	1 TYES	1		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
-114		Y or	-11								1		T VEAINT

CAUSE (Disease or injury that initiated events resulting in death) LAST	COUE TO (OR AS A CONSEQUER	NCE OF):			
	na contributing to death but not reau	iting in the u	ndarlying cause given in P	art I. 24a. WAS AN AUTOPSY PERFORMED? 1  YES 2 0	24b. WERE AUTOPBY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (Chec	k only one)	
EXAMINER?	HOSPITAL: 1   Inputient 2   ER/Outpatient 3   I	OTHE	R: sing Home 5 🗆 Residence 6	Other (Specify)	
27. MANNER OF DEATH  1 Netural 5 Pending Investigation	26e. DATE OF INJURY (Month, Dey, Year)	b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCC	URED
3 Suicide 6 Could not be detarmined	26e. PLACE OF INJURY — At home, building, etc. (Specify)	farm, street, fac	tory, office	28f. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,
290. CERTIFIER Check only	HCIAN: To the best of my knowledge, death	occurred at the t	time, data and place, and due to	o the cause(a) and manner as state	d.

296. SIGNATURE AND TITLE OF CERTIFIE

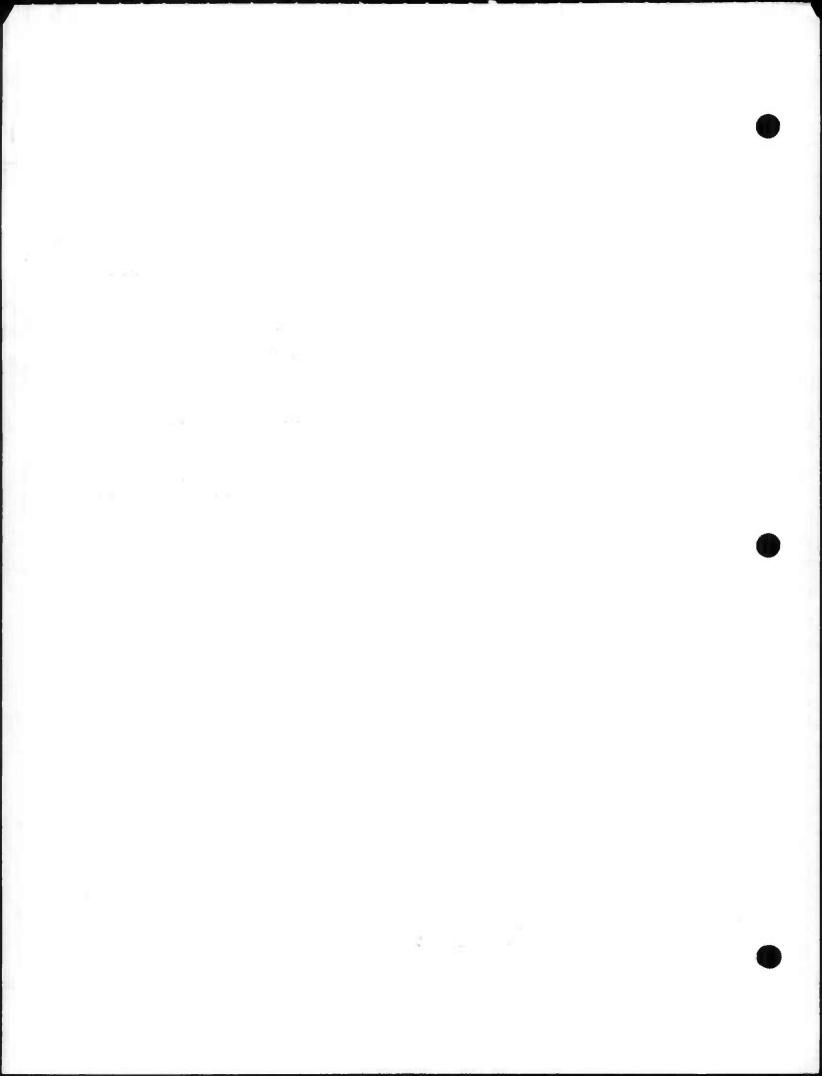
(kha 'b			
30. NAME AND ADDRESS OF PE	RSON WHO COMPLETED CAUSI	OF DEATH (ITEM	27) (Type, Print)

32. REGISTHAR'S SIGNATURE



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DIVISION	

		1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H			GIENE		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA		YEAR 3. TI	IME OF DEATH
		4. SOCIAL SECURITY NUMBER		WALKER		1	MAY	24 19	95	4:45PM
pin		577-74-2483	1 🗆 M 2 🖔 F	yrs. last birthday) 40 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT	954	NEW YOY	E (State or Foreign
2, 3 should	CTOR	90. FACILITY NAME (If not Institution, give of Prince George's Hos	pital Center			or location of di	EATN		George	e's
Jes 1,	EG	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY	1	10c. CIT	Y, TOWN OR LOCAT	ITON			10d.	INSIDE CITY
020 physician. burial-transit permit. Pages 1,	L DIRE	Maryland Prince	George's		100	Blade	nsburg	Table Outries	1 🔀	YES 2 NO
an. ransit pe	NERAL	4283 58th Aven				207		U.	S.A.	SOUNTHY?
1 P 2 P	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN ( FORCES? 1 ☐ YES  IF YES, GIVE WAR OR DAT	U.S. ARMED 2 VINO ES	If yes, sp	endent of HISPAN ecify Cuben, Mexice 200 NO Specify	n, Puerto Rican, et	Ify Yes or No—	Black, White	mericen Indian, te, etc. Black
21215 I or attend for use as	ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed)	18e. DECEDENT'S (Give kind of title. Do NOT us	USUAL OCCUPATION Work done during mose retired.)	ON st of working	16b, KIND O	F BUSINESS/INDU	STRY	
ND hospita ached	립	10th grade	College (1-4 or 5+)		Hous	sekeeping		estic		
2 2 2	6 444	17. FATNER'S NAME (First, Middle, Last) Azar Ashley	<u>'</u>					Howe11		
	2	1901, INFORMANT'S NAME (Type/Print) Viola Townsend (Mother	r)	2142 30	Oth Street	nd Number or Rural I N.E. Wa	Shington,	D.C. 200		
- è a		20a. METHOD OF DISPOSITION  1 (X Suriel 2 Cremano 3 Rem. 4 Donation 5 9they (Specify)	oval from State 20b.P	LACEAND DATE	of disposition (Na	rial Park	May 31, 1	e. Location — CII 1995 Land		Maryland
BALTIMOR  ter death. Page 6 ma  the funeral director, p  val.		21. SIGNATURE OF PURERAL SERVICE LIC	auli	0/		ins Funera		ic.		
rs after do the it by the it		23. PART I. Enter the diseases, or c	complications that caused in	the death. Do r		Hunt Place				
ely filled in nation, or		IMMEDIATE CAUSE (Finel	List DRIV DRE CAUSE DR ESC LIST DRIVE DRE CAUSE DREAM AND AND AND AND AND AND AND AND AND AND	on line.	44 VIVUE		1 mm		ξ,	Approximate Interval Batween Onset and Death
certificate be executed by spiritual and the burn of t	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	7 / Fi:	/				
9 5 2		PART II. Other significent condition	e contributing to deeth but	t not resulting	In the underlying	ceuee given in	Part I. 24s. W	AS AN AUTOPSY	24b. WERE	E AUTOPSY FINDINGS
that the that the that the that the that the the the the the the the the the th	일	Tuberculosis (pulmon	iary); chronic		failure		PE	ES 2 NO	AMAIL	ABLE PRIOR TO PLETION OF CAUSE EATH?
v requires been sign rt. of Healt	Σ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YE	SINOI	UNCERTAIN			10	YES 2 NO
e e e		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28		TN (Check only one)	OTTOLKIZAT				
SICIAN: The certificate the State		1 TYES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpet			e 5 🗆 Residence	6 Other (Specify	1)		
是等	ву Рн	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	URY AT RK? (ES 2 NO	28d. DESCRIBE N	IOW INJURY OCCU	RED	
TTENDI TOR: A after de	<u>a</u>	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — building, atc. (Specify	At home, ferm, s	street, tectory, office		281. LOCATION (S City or Town,	Street end Number or Stete)	Rural Route N	lumber,
¥ 4 5 =	2		CIAN: To the best of my knowled R: On the bests of examination e							menner es stated.
TO THE HOSPI TO THE FUNEF LE filed within	H	296. SIGNATURE AND TITLE OF CENTIFIED	ly MoDe			DD 56	98	29d. DATE S	ZS19	1. Day, Year)
(4)		H. Themas of person who	A.D. Prince	GEOVER	S HOLDE	tal Cont	er chev	ent. M	D 2	0785
0		31. DATE FILED (Month, Day, Year)	2 REGISTRARIS SIGNAL	MRE		• )	1	//		



permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

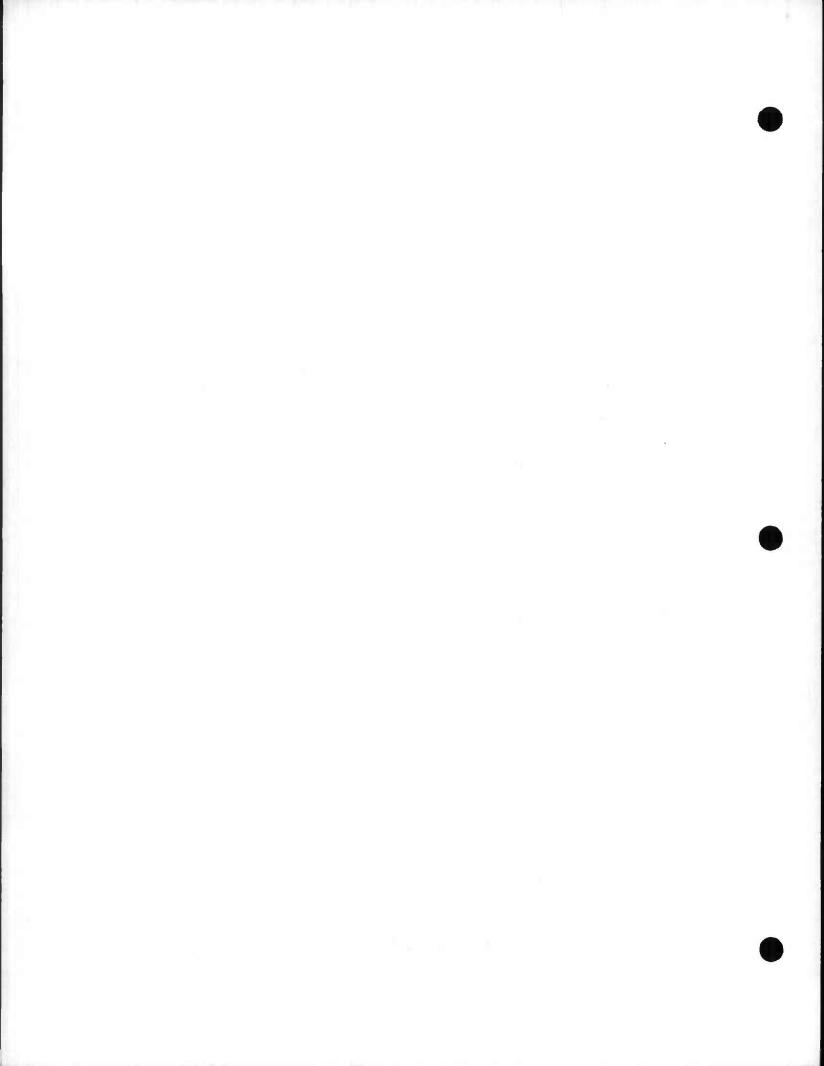
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.		tending physician.	as the burial-transit		
OTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within "Chours after death. Page 6 may be retained by OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified a		y the hospital or a	e detached for use		rt once.
OTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct effied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner my		may be retained by	or, page 5 should b		ust be notified a
OTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the filed within 72 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or resMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medi		after death. Page 6	y the funeral direct	moval.	ical examiner mu
OTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and e filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bur MPORTANT: If Item 26 is marked, or item 23 shows any injury, or other traumatic		ted within a nours	completely filled in t	ial, cremation, or re-	event, the med
OTHE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death OTHE FUNERAL DIRECTOR: After this certificate has been signed by the affer of filed within 72 hours after death with the State Dept. of Health and Mental is MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or		certificate be execu	oding physician and	Hygiene prior to bur	r other traumatic
O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requ TO THE FUNERAL DIRECTOR: After this certificate has been e filed within 72 hours after death with the State Dept. of I MPORTANT: If Item 28 is marked, or Item 23 sho		ires that the death	signed by the atten	Health and Mental	ws any injury, o
O THE HOSPITAL OR ATTENDING PHYSIS OT THE FUNERAL DIRECTOR: After this or of filed within 72 hours after death with I MPORTANT: If Item 28 is marked,		CIAN: The law requ	ertificate has been	he State Dept. of I	or item 23 shor
O THE HOSPITAL OR. O THE FUNERAL DIRE of filed within 72 hours		ATTENDING PHYSIC	CTOR: After this ce	s after death with t	28 is marked,
	1	O THE HOSPITAL OR	THE FUNERAL DIRE	e filed within 72 hour.	MPORTANT: If item

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEA		IENTAL HYGIEN	Ε	
	1. DECEDENT'S NAME (First, Middle, Last) VINCENT Ri	cardo WHIT	AKER			2. DATE OF DEATH	1995	3. TIME OF DEATH
1	P. D. Tilletter, person				F UNDER 24 HRS.	7. DATE OF BIRTH 1 (Month, Day, Year)		RTHPLACE (State or Foreign unity)
	577-78-4823 12 9e. FACILITY NAME (If not institution, give street		8 YRS.			January 20	), Was	shington, D.C.
E.	Washington Adven			E CITY, TOWN OR	location of DEA 1a Park	TN	9c. COUNTY O	omery
5	RESIDENCE OF DECEDENT						nont(	
DIRECTOR	100.000111	e Georges		rown or Location Hyattavi				10d. INSIDE CITY LIMITS?  1 X XYES 2 \( \text{NO} \) NO
ME	10. STREET AND NUMBER 6500	Riggs Road			P CODE		10g. CITIZEN C	F WHAT COUNTRY?
FUNERAL	Hyattsville Manor I	Health Care 2. WAS DECEDENT EVER IN			20783			States
	1XXNever Married 2  Married	FORCES? 1 YES	2 [X] NO	if yes, specif	y Cuban, Maxican.	C ORIGIN? (Specify Yea Puerto Rican, etc.)	8	ACE — American Indian, leck, Whita, etc. pecify: Black
ED BY	3 Widowed 4 Divorced				Of the obscity.			
ETE	15. DECEDENT'S EDUCATI (Specify only highest grade continued to the contin	npleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	k done during most o	of working	16b. KIND OF BUS	SINESS/INDUSTR	Y
COMPLET	12th grade	Total Strain	Mainte	nance Wo	rker	None		7.5
	17. FATHER'S NAME (First, Middle, Last) Paul Wentwo	outh	VIII to a locate	_1		E (First, Middle, Maiden		
BE	19a. INFORMANT'S NAME (Type/Print)	31 (1)	Whitaker	ODRESS (Street and	Hazel Number or Burel Br	Berni ute Number, City or Town		Calhoun
5	Hazel B. Whitaker	(mother)						on,D.C.20018
	20a, METNOD OF DISPOSITION  1X XBurial 2 Gremation 3 Removal	from State 20b.	PLACE AND DATE OF D	DISPOSITION (Name	of	DATE 20c. LO	CATION - City or	Town, State
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	Glenwood		ry 5/	31/95 Was		
	Im on La	Incy O	Emmel			Latney venue,N.W.	's Fune :Wash.[	eral Home
	23. PART i. Enter the diseases, or com ahock, or heart fellure. List	plications that caused	the death. Do not					Approximats
	iMMEDIATE CAUSE (Finsi disease or condition resulting in death) s	algine	10	und	pour	ux fyr	elem	Unterval Batwesn Onset and Death
z		DUE TO (OR AS A	CONSEDUENCE OF):		V	0		
OIT	Sequentially list conditions, If any, leeding to immediate	DUE TO (OR AS A	CONSEDUENCE OF):					
길	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEDUENCE OF):					
CERTIFICATION	resulting in death) LAST							
L C	PART II. Other significant conditions of	ogtributing to death be	at not resulting in t	the underlying c	ause given in P	nt 1. 24s. WAS AN		14b. WERE AUTOPSY FINDINGS
20	pintrutes,	frimus.	uymi	1 m	umn	PERFOR	N so	AMAILABLE PRIORI TO COMPLETION OF CAUSE OF DEATHY
MEDIC	semany	usun	- am	MINOH	V.	_		t □ YES 2 □ NO
PHYSICIAN:	DIDITOBACCO USE CONTRIS	-	M. PLACE OF DEATH		UNCERTAIN			
SIC	1 YES 2 NO	OperTAL:	O	THER:	S ☐ Residence 6	Other (Specify)		
PH	27. MANNER OF DEATH  1 Thatural 5 Theoding	28s. DATE OF INJURY (Month, Day, Year)	286. TIME O	Y WORK	1	Ind. DESCRIBE HOW IN	JURY OCCURED	
BY	2 Accident Investigation	28s. PLACE OF INJURY	- At home, farm, street		3 [] NO	DRI. LOCATION (Street a	ad Rombin on the	- December 1
TED	4 Homicide determined	building, etc. (Speci	50		1	City or Twen, State)	no reaction of real	w result restricte.
COMPLET		N: To the best of my knowle						
SON	2 MEDICAL EXAMINER: 0	In the basis of empiration	and/or investigation, is	in my opinion, dwatt	n socured at the ti	me, date and place, and	due to the caus	e(s) and manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CENTURES	MW	SW	(a) A	DOIY	19	P NO	125, Ugs
-	30. NAME AND ADDRESS OF PERSON WHO CO			wasiiii	ngton Ac	ventist H	ospital	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE	II Avenue	e, Takom	a Park, M	aryland	20912
	MAY 301995 Julia	d'audion hardo	Щ					

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O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  OTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. Of Health and Mental Hygiene for to bunial, cremation, or removal.  WENTIAL IN IN THE MARKET OF THE ACCOUNT OF THE PROPERTY OF THE PROP	-
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	1 - FOR REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATH	
	Dorothy Lee	Walton				MONTH	30 1995	1:57 A M	
	4. SOCIAL SECURITY NUMBER		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	4.1	HRTHPLACE (State or Foreign		
	011 01 1200	□ M 2 🔀 F	32 YRS. M	DAYS DAYS	HOURS MIN.	July 17		Canada	
_ [	9a. FACILITY NAME (If not Institution, give street	t and number)	9	b. CITY, TOWN C	R LOCATION OF DE		9c. COUNTY		
DIRECTOR	Anne Arundel Medi	cal Center		Α	nnapolis		Anne	Arundel	
H	10a. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT				10d. INSIDE CITY LIMITS?	
		tgomery		Rocky	He			1 - YES 2 NO	
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
NE	2279 Glenmore Te				2085			d States	
F	11. MARITAL STATUS  1 Never Married 2 Married	2. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED	13. WAS DEC	ENCENT OF HISPAN Holfy Cuban, Maxica	NC ORIGIN? (Specify n, Puerto Rican, etc.)	Yes or No- 14.	RACE — American Indian, Black, Whita, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ITÉS'^\	1 🗌 YES	2 NO Specify	y:		Specify: White	
G	15. DECEDENT'S EDUCAT	ION	16a. DECEDENT'S US	UAL OCCUPATIO	N .	16b, KIND OF	BUSINESS/INDUST		
E	(Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 +)	(Give kind of work life. Do NOT use n	done during mo. etired.)	st of working				
A P	12		Direc	tor			Clothing	Sales	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Mai	den Sumame)		
BE (	Walter Lloyd Yate	S			Vi	rginia Lee	e Ramsey	/	
5	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or			
-	Eleanor L. O'Sulliv	'an	2279	Glenmo	re Terra	ce Rock	ville, MD	20850	
	20a, METHOD OF DISPOSITION  1  Burial 2  Cremation 3  Remove	I from State 20b.	PLACE AND DATE OF I	DISPOSITION (Na	me of	DATE 20c.	LOCATION - City	or Town, Stata	
	4 Donation 5 Other (Specify)	A	Arlington N	lational	Cemete	ry 6/2/95.	Arlingto	n, Virginia	
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME AN	D ADDRESS OF FA	dury John 1	M. Taylo	r Funeral Home	
	Mumel	Dions	4					napolis, MD	
	23. PART I. Enter the diseases, or con	pilications that caused	the death. Do not	anter the mo	de of dying, auci	h as cardiac or re	apiratory arrest,	Approximate	
	shock, or heart failure. List only Dna cause Dn-each line.  IMMEDIATE CAUSE (Final  Onset Table 1997)								
	disease or condition resulting in death)	Llyocan.	DIAL 1	NAM	ETCUN			3 d	
	110	DUE TO (OR AS A	CONSEQUENCE OF):						
NO	Sequentially list conditions,								
Ā	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
E	resulting in death) LAST								
	6								
AL	PART II. Other aignificant conditions of	ontributing to death bu	ut not resulting in t	ha underlying	cause given in	Part I. 24s. WAS	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS	
8						1 □ YES	2 X NO	COMPLETION OF CAUSE OF DEATH?	
ME						_		1 TYES 2 NO	
Ž.	DID TOBACCO USE CONTRIB				UNCERTAIN	1 🗆			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	QSPITAL:	26. PLACE OF DEATH (	Check only one) THER:					
₹	1 YES 2 (NO 1	XInpetient 2 - ER/Outpe	itlent 3 DOA 4	☐ Nursing Home		8 Other (Specify)			
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME O	WO	PK?	28d. DEŞCRIBE HO	W INJURY OCCURE	D	
B	2 Accident Investigation	20 - D/ 405 05 D/ H/F/			ES 2 NO				
0	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, etc. (Speci	— At nome, farm, stree (y)	it, factory, office		281, LOCATION (Stre City or Town, Str		iral Route Number,	
<u> </u>	29a, CERTIFIER		_						
MP	(Check only CERTIFYING PHYSICIAL								
COMPLETED	2 MEDICAL EXAMINER: (	In the basia of sxamination	and/or investigation, is	n my opinion, de	ath occured at the	time, data and placs,	and due to the cau	se(s) and menner as stated.	
H H	29b. SIGNATURE AND TITLE OF CERTIFIER	-4.0			29c. LICENSE NUM		29d. DATE SIG	NED (Month, Day, Year)	
2	SO NAME AND ADDRESS OF PERSON WHO C	un uns			D3071	88	May	31 1995	
	John D. Jackson, M	.D. 1833 Fo	rest Drive	Annap	olis, MD	21401 (4	10-267-92	211)	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA							
	JUN 08 199!	del: Asi	Leon Rawfall						
		77.00							



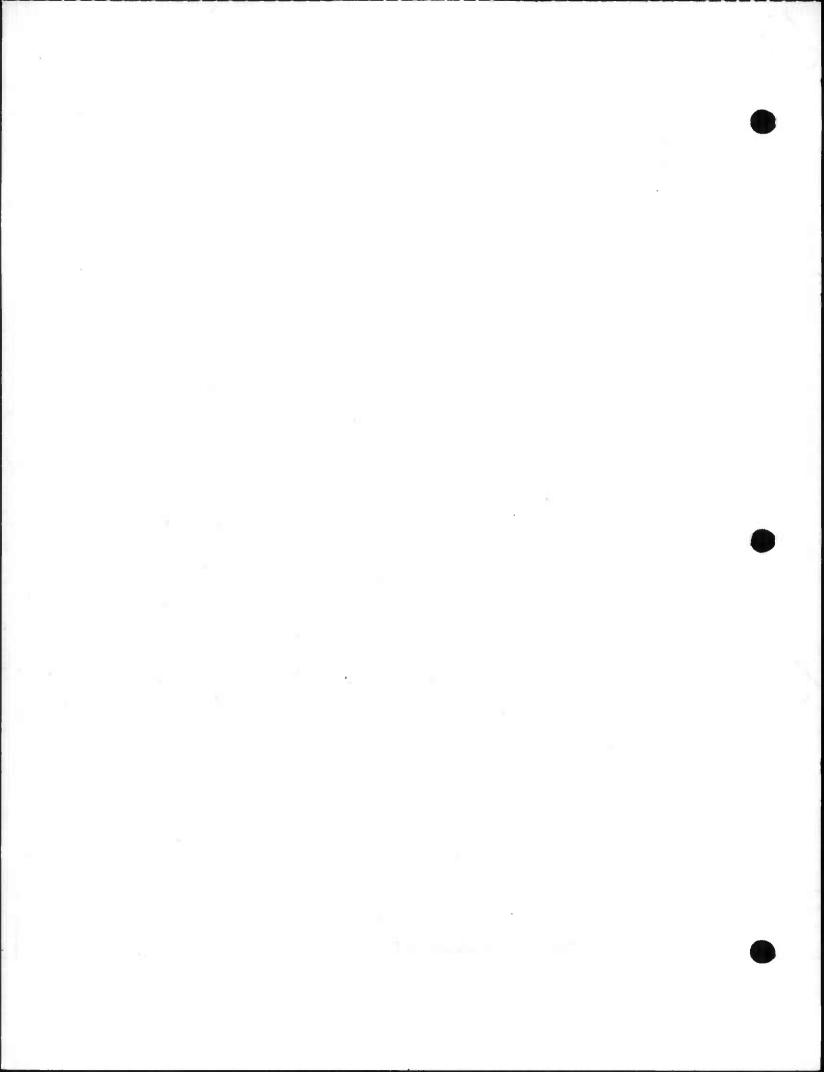
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BALTIMORE, MARYLAND 2	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any ours after death. Page 6 may be retained by the hospital of
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	J.
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permit. Pages 1, 2, 3 should or attending physician. ğ detached once. should be notified at page 5 s must be director shows any injury, or other traumatic event, the medical examiner funeral filled in by the fion, or removal. nd completely fille burial, cremation, and the attending physician Mental Hygiene prior to Dy and OR ATTENDING PHYSICIAN: The law requires to certificate has been h the State Dept. of I Item 23 the the with t is marked, After t DIRECTOR: / 28 Item TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 ho

						20	
1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND / DEPAR CERTIF	TMENT OF I		MENTAL HYGIENE REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		T
Margaret		Worthington			June 5	1995	ı
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a, BIRT	
216-44-9671	1 M 2 VF	OE YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	Cour	ntry)

3. TIME OF DEATH 8:10 P LACE (State or Foreign June 6 1899 | Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Meridian Nursing Center Severna Park Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MD Anne Arundel Severna Park 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 24 Truckhouse Road 21146 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or It yes, specify Cuben, Maxican, Puerto Rican, atc.)

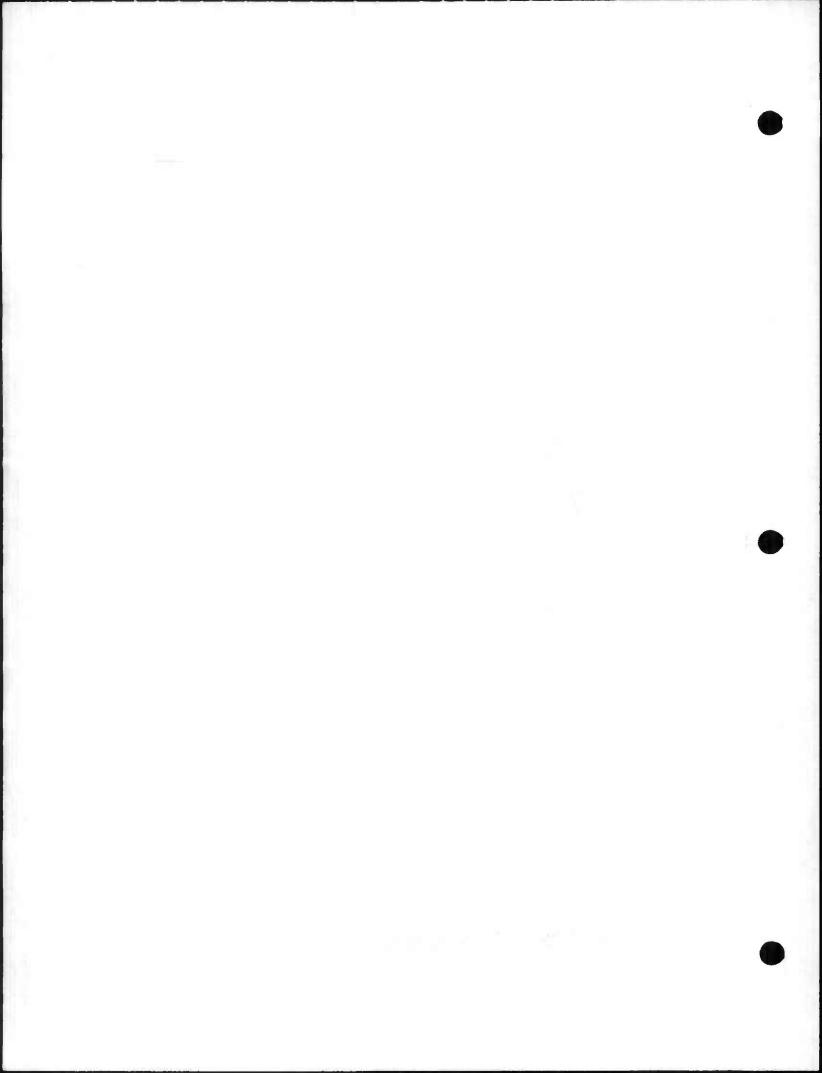
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 X Never Married 2 Married ВУ 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 18a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Ш Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Secretary Administration/U.S.N.A. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph M. Worthington Margaret Randall BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 1688 Coventry Place Annapolis, Maryland 21401 Martin Goldsborough 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6/7/95 Brentwood, Maryland MATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 23. PART I. Enter the diseases, or complic tions that caused the de-shock, or heart failure. List only one cause on each line. tions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximata interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition resulting in death) neunania DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, NSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in death) LAST PART II. Other significent conditions contributing to feeth, but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE lerosis 1 YES 2 XNO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only on HOSPITAL: OTHER:
4 | Nursing Nome 5 | Realdence 8 | Other (Specify) 1 YES 2 00 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF CEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural Pending investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On th investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner ea stated. 296. SIGNATURE AND TITLE OF CERRIFIE 29¢. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D22206 June 6, 1995 2 Mustafa Oz. M.D. 273 B Peninsula Farm Road Arnold, MD 21012 (410-544-2006) 32. REGISTRAR'S SIGNATURE JUN 08 1995 Jalin Davidson Randall



1 - FOR STATE REGISTRAR

			4. SOCIAL SECURITY NUMBER	SEX 6. AGE	(In yrs. lest birthday)	F UNDER 1 YEAR		DATE OF DEATH MONTH DATE OF BIRTH (Month, Day, Year)	1 95	3. TIME OF DEATH 0740 A THPLACE (State or Foreign		
	DIOONS		212-32-2069  9a. FACILITY NAME (If not Institution, give stree	X /	70 YRS.	b. CITY. TOWN (	DR LOCATION OF DEAT	AN. 10 19		RYLAND		
6	, 2,	DIRECTOR	ANNE ARUNDEL MEDI	CAL CENTER		ANNAPOI			ANNE A			
į	L ages	IRE(	10a. STATE 10b. COUNTY			TOWN OR LOCAT	TION	-		10d. INSIGE CITY LIMITS?		
	Ē.		MARYLAND ANNE 100. STREET AND NUMBER	ARUNDEL	ANNA	POLIS	. ZIP CODE		10g. CITIZEN OF	TYPES 2 NO		
	Ties in	FUNERAL	2112 BAY RIDGE AVE	NUE			21403		SA			
21215-0020 al or attending physician.	2	ВУ	11. MARITAL STATUS 1 Never Married 2 💹 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER I FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPANIC ecify Cuban, Maxican, F 2 NO Specify:	ORIGIN? (Specify Yes Puerto Rican, atc.)	Spe	CE — American Indian, ick, White, atc. ecity: A C K		
1215-0	3	回	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION mpleted)	16a. DECEDENT'S US	k done during mo	ON isl of working	16b, KIND OF BUS	SINESS/INDUSTRY	101		
AND 21	3	COMPLET	6th	College (1-4 or 5 +)	HOUSEWIF	wtired.)		НОМЕ				
A at	<b>75</b>	BE CO	17. FATHER'S NAME (First, Middle, Last) DOUGLAS DUVALL				18. MOTHER'S NAME PEARL		Sumame)			
MARYI e retained by	> =	5	JAMES WILLIAMS				E AVENUE			1403		
LTIMORE, ath. Page 6 may be	ust be		20a. METHOD OF DISPOSITION 1) Burial 2 Cremation 3 Remove	ol from State 201	D. PLACE AND DATE OF	DISPOSITION (Na	ime of	DATE 20c. LO	CATION — City or	Town, State		
Page 6 m	ner m		4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICEN		LL CREST		Y 5/30		POLIS,MI	0		
after death. Page			Larry J	Reese			& SONS MO			. 0.7		
BOX 68760 cate be executed within 24 hours	e prior to burial, cremation, or re	RTIFICATION	Approximate abook, or heart failure. List only one cause on each line.  Approximate interval Batweer Onset and Dasti Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):									
O - 2	후 느	S	resulting in death) LAST									
RECORD: requires that the	pt. of Health and Mental	MEDICAL	PART II. Other algolificant conditions of	contributing to death t	but not resulting in	the underlying	g cause given in Pa	rt i. 24s. WAS AN PERFOR	MED?	Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
6	Dept. o	AN	DID TOBACCO USE CONTRIB	BUTE TO CAUSE C	F DEATH YES		UNCERTAIN					
VITA IAN: The	th the State Dept.	/SICIAN:	EXAMINER?	OSPITAL:	_   C	THER:	e 5 Residence 6	Other (Specify)				
N O P	N SE	ву РНУ	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (	Y WO	URY AT 26 PK? /ES 2 NO	Id. OESCRIBE HOW II	NJURY OCCUREO			
OR ATTENDING	after d	ETED 8	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spe	<ul> <li>At home, farm, stre city)</li> </ul>	at, lactory, office	26	BI. LOCATION (Street a City or Town, State)	nd Number or Rura	l Route Number,		
B 88	in 72 hours (T: If Item	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER:							(6) and manner as stated.		
TO THE HOSPITAL	be filed within IMPORTANT:	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  SO. NAME AND ADDRESS OF PERSON WHO CO	llen 1	up		29c, LICENSE NUMBE		29d. DATE SIGNE	(Month, Day, Year)		
			John Jackson	1 1833 Po	NEST DI	, Au	espoles, p	ed 2180	/			
			JUN 08 1995	32. REGISTRAR'S SIGN	PHAR RANGELL							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAIL	RTMENT OF I	HEALTH AND	MENTAL HYGIEN			
		1. OECEDENT'S NAME (First, Middle, Last)				C-17	2. DATE OF OEATH		3. TIME OF DEATN	
			WILT				JUNE 0	9, 199	5 0630 A M	
		70 C C C C C C C C C C C C C C C C C C C	5. SEX 6. AGE (II	in yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	C	IIRTNPLACE (State or Foreign country)	
should		216-23-9407  9a. FACILITY NAME (If not institution, give street	A	) 1110.	9b. CITY, TOWN	OR LOCATION OF D	May 4, 197	72 Per	nnsylvania	
1. 2. 3	CTOR	RT.40 2MI. EAST		SVILLE		SVILLE	EATT	GARR		
nit. Pages	DIRECTOR	Maryland Garret	TION			10d. INSIDE CITY LIMITS? 1 Ty YES 2 NO				
t permit.	3AL	10e. STREET AND NUMBER			10	of. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
ian. -transi	FUNERAL	22 Bittinger Road	THE PROPERTY EVEN IN		1	21536			USA	
MARYLAND 21215-0020 retained by the huspital or attending physician. 5 should be denoted for use as the burial-transit notified at once.	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENOENT OF HISPAI pecify Cuban, Maxica B 2 TNO Specif	NIC ORIGIN? (Specify Yes an, Puarto Rican, atc.) fy:		RACE — American Indian, Black, White, etc. Specify: White	
21215 if or attend for use as	ETED.	15. DECEDENT'S EQUICATI (Specify only Algheir grade con Elementary/Secondary (9-12)	nioN mpleted) College (1-4 or 5 +)	18a. DECEDENT'S (Give kind of life. Do NOT u	S USUAL OCCUPATION  work done during mouse retired.)	ON osl of working	16b. KIND OF BUS			
AND 2 the hospital detached to ance.	COMPL	10 th	NOW THE CONTROL OF THE CO.	Heavy E	Quip Ope	erator	Roads	Constru	uction	
/LAN y the ho be detact at once.	_	17. PATHER'S NAME (First, Mitths, Last)				18. MOTNER'S NA	AME (First, Middle, Malden	*		
Sained by should be diffied at	BE	Robert Loye Wilt		T 405 MAII IN	A ADDRESS (Stand of		Ann Finzel  Route Number, City or Town			
	2	Sheila A. Wilt						n, State, Zip Code 21536	,)	
ORE 6 may clay pa		Sheila A. Wilt  P.O. Box 311, Grantsville, MD 21536  20a. METHOD OF DISPOSITION 15 Burdel 2 Cremetion 2 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of camelery, cremelory or other place) Finzel Cemetery June 12, 1995 Frostburg, MI								
ALTIMOR death. Page 5 m funeral director. sxaminer mus	1	21. SIGNATURE OF FUNERAL SERVICE LICENS		TINET CE	22. NAME A	ND AODRESS OF FA	CILITY		1, MD	
BALTIN by death, Pag the funeral de wal, I examiner		· Ll Lan	, O Jews	aw			1 Homes, P		- 01506	
nours after or remove medical		23. PART I. Enter the diseases, or com shock, or heart failure. List	iplications that caused	the death. Do	not enter the mo	ode of dying, suc	Grantsy ch as cardlac or reapi	ratory arrest,	Approximata	
withheat I upletely fi cremation.		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A	typle	DF):	Junes	5		Interval Between Onset and Death	
BOX 68 ficate be execute physician and co ne prior to buria ter traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A O							
0 4 8 5 6	SERTI	that initiated events resulting in death) LAST	age to fail to	CONSECUENCE O	rr ):					
Q # € ₹ Ē	7	PART II. Other aignificant conditions of	ontributing to death bu	it not resulting	In the underlying	g cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS	
RECORE requires that the sen signed by of Health and shows any in	MEDIC						YES 2		COMPLETION OF CAUSE OF DEATH?	
	M	DID TORACCO LISE CONTRIB	PLITE TO CALLEE OF	DEATH V	FC TO NO F	7 111105554			1 YES 2 NO	
12 Per a	AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL			ATH (Check only one)		иЦ			
- F 2 7 6	PHYSICIAN:		IOSPITAL:		OTHER:		8 X Other (Specify)	ROADWA	v	
F 5 8 F	PH	27. MANNER OF OEATN	38e. DATE OF INJURY (Agenth, Life, Year)	28b, TIN	WE OF 28c. INJ		200 DESCRIBE NOW II			
ON ON OING PHYS After this death with	B	1 Netural 5 Pending Accident Investigation	69195	030	101	YES 2 X NO	unvero	tauto	recident	
TOPR:	ETED	5 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specifi		etreet, fectory, office		281. LOCATION (Street a	Number or Ru	ral Aoute Number.	
코코오노	COMPL	29e. CERTIFIER (Check only 27 MEDICAL EXAMINER: 0	N: To the best of my knowle On the basis of examination						se(s) and manner as stated.	
TO THE HOSPITA TO THE FUNERA DE filed within 7 IMPORTANT:	BE	294 SIGNATURE AND TITLE OF CERTIFIER	orfo M	D		O.C.M	T1 (200)		NED (Month, Day, Year) E 10, 1995	
	2	J. HON LOS	TA			et, Bal	timore, M	Maryla	nd 21201	
	8	JUN 1 2 1995	32 AEGISTRAR'S SIGNAT	-Rawfall						

may be retained by the hospital or attending physician. Or page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should on the page 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020

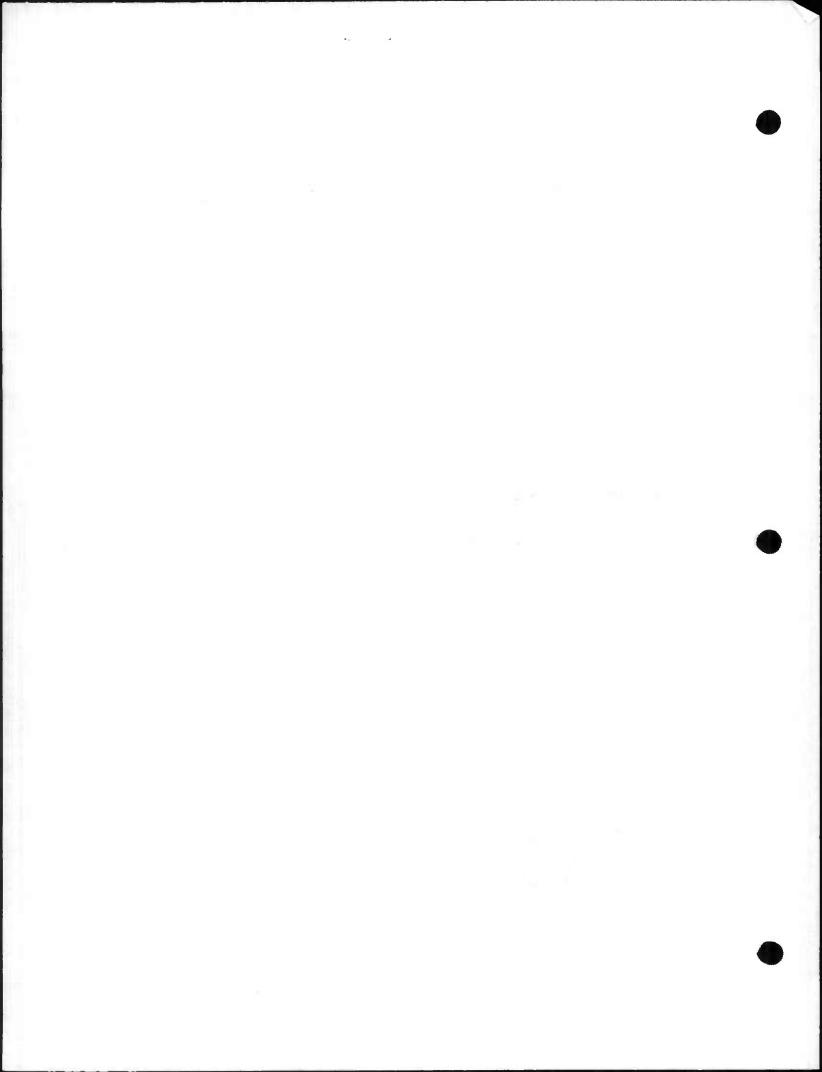
DIVISION OF VITAL RECORDS P.O. BOX 68760

DALLIMORE, MARTLANT	after death. Page 6 may be retained by the hosp	by the funeral director, page 5 should be detached	nova. Ical examiner must be notified at once.
CHIEF TECONDS, T.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	De med within 72 nous are dean with the State Dept. Or results and wental rygere prior to burial, crematon, or removal. IN 16 m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
1	TO THE HOSPITAL OF	TO THE FUNERAL DIS	IMPORTANT: If Ite

									95	)	874	-}
	1 - FOR STATE REGISTRAR	STATE OF MARY			MENT OF H		MENTA	AL HYGIEI	-			
	1. DECEDENT'S NAME (First, Middle, Last)		14					E OF DEATH			3. TIME OF OEA	TH
	Anthony Le	eftridge		W	illett		Jun	e 7, 1	995	YEAR	10:15	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AC	GE (In yrs. lest bi	-	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 047	OF BURTH	773	8. BIRTH	PLACE (State or Fo	oreign
	216-30-4484	1 1 M 2 □ F 6	57	YRS.	MONTHS DAYS	HOURS MIN.	(Mon	ith, Day, Year)	1927	Mars	) land	
	Se. FACILITY NAME (If not institution, give st	treet end number)			9b. CITY, TOWN C	R LOCATION OF		20,	-	NTY OF D		
Œ							DEATT		1		CAIN	
5	Physician Memoria	ii nospitai			La Pla	ata			Char	les		
DIRECTOR	10a. STATE 10b. COUNTY	,	- 1	10c. CITY,	TOWN OR LOCAT	ION					10d, INSIDE CITY	,
5	Maryland St. 1	Mary's		Mec	hanicsv	ille				- 1	LIMITS?	940
4	10e. STREET AND NUMBER	7			101	. ZIP CODE			10a. CITI	ZEN OF V	HAT COUNTRY?	110
FUNERAL	6925 Waldorf-Leon	ardtown Ros	Ы			2065	9			USA		
Ž I	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARME	n .	13 WAS DEC	ENDENT OF HISP		INO CONTRACTOR N	a sa Na			
	1 🗋 Never Married 2 🔀 Married	FORCES? 1 Y	ES 2 NO		If yes, spi	cify Cuben, Maxi	can, Puarto	Rican, etc.)	e or No —		— American Indi , White, stc.	en,
ВУ	3 Widowed 4 Divorced	WWTI	1 DATES		1   YES	2 NO Spec	offy:			Specifi	nite	
0	15. DECEDENT'S EDUC	CATION			SUAL OCCUPATIO		16	b. KIND OF BU	SINESS/IND		11 00	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give	kind of wo NOT use	rk done during moi retired.)	st of working	100			10.00		
립	9		Ow	ner				Contri	iction	n Cor	mpany	
COMPLET	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S P	AME (First.				1 7	-
	Walter A. Willett					Ona	1 M	Hender	rson			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. N	AAILING A	DDRESS (Street e					Codel		
5	Sharon J. Scott				indsbro							
	20e. METHOD OF DISPOSITION				DISPOSITION (Ne	<u>.</u>	DA		CATION —		wa State	
	15 Buriel 2 ☐ Cremation 3 ☐ Remo				emorial			-10 Wa	dorf	MD	wn, otale	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSE				D ADDRESS OF		iq via.	Lacit	1111		
	► K/L () 41 ()	Mark C	. Broh	awn	Huntt	Funera	l Hon	ne, Ind	J			
-	19uc/8/2		100053		P. O.	Box 15	6. Wa	aldorf	MD 2	20604	4-0156	
	23. PART I Enter the diseases, or c shock, or heert failure. I	omplications that cause or	sed the deeth n each line.	h. Do no	t anter tha mo	de of dying, au	ich aa car	rdiec or reap	iratory am	pat,	Approxim- interval B	
	IMMEDIATE CAUSE (Finel	0.11	1								Onset and	
	disease or condition resulting in death)	410stat	0 6	2ru	<u></u>						Hay	
- 1		DUE TO (OR A	S A CONSEQUE	INCE OF)								
S	Sequentially list conditions,											
Ē	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (ON A	S A CONSEQUE	ENCE OF):								
길	CAUSE (Disease or injury	DUE TO (OR A	S A CONSEQUE	NOT OF								
Ē	that initiated events resulting in deeth) LAST	50C 10 (011 X	3 A CONSCOOL	AVCE OF ).								
CERTIFICATION		1										
_	PART II. Other algnificant conditions	s contributing to death	but not resi	ulting in	the underlying	ceuse given i	n Part I.	24a. WAS AN		24b.	WERE AUTOPSY FI	NDINGS
5								PERFO			AVAILABLE PRIOR COMPLETION OF C	
밀								1 1 163	NO NO	- 1	OF DEATH?	10
-	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH	YES	П NO П	UNCERTA	IN []				1 163 2 1	10
A	25. WAS CASE REFERRED TO MEDICAL		_	_	(Check only one)	OTTCLKIA						
PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO	HOSPITAL:	utpatient 3 🗆		OTHER:	E □ Booldono		(016.1				
H	27. MANNEY OF DEATH	26e. DATE OF INJUR	Y 2	6b. TIME			1	SCRIBE HOW	NJURY OCC	URED		
	1 Natural 5 Pending	(Month, Day, Yes.	7)	INJUI	M 1 Y	RK?				01120		
BY	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJU	IRY — At home.	farm, atr			261 1 00	CATION (Street	and Number	or Rural D	nuto Mumber	
	4 Homicide B Could not be	building, etc. (S	(pecify)		, , , , , , , , , , , , , , , , , , , ,		City	or Town, Stete	)	pr riorer ri	oute Number,	
COMPLETED	29a. CERTIFIER											
MP	(Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my kn										
8		R: 0) the livels of examina	ron end/or inve	atigation,	in my opinion, di	rath occured at th	e time, date	e end plece, er	nd dua to the	cause(s)	end manner ee st	ated.
BE	296. SHOMATURE AND TITLE OF CERTIFIER	/				29c. LICENSE N	JMBER	1	29d. DATE	SIGNED	(Month, Day, Year)	
0	7 10 170	-				D27	349	8	<b>▶</b> 6	1 1	+	
-	30. NAME AND ADDRESS OF PERSON WHO		DEATH (ITEM 2	7) (Type, P	700 O	Ide Lin	e Cer	nter,	Suite	100	***	
-	Howard M. Haft, M	.D.				rf, Mar						
- 11	24 DATE CHIED (March, Day March											

32. RESISTAR'S SIGNATURE Partall

Howard M. Haft, M. 31. DATE FILEO (MONTH) Day, Well 1995



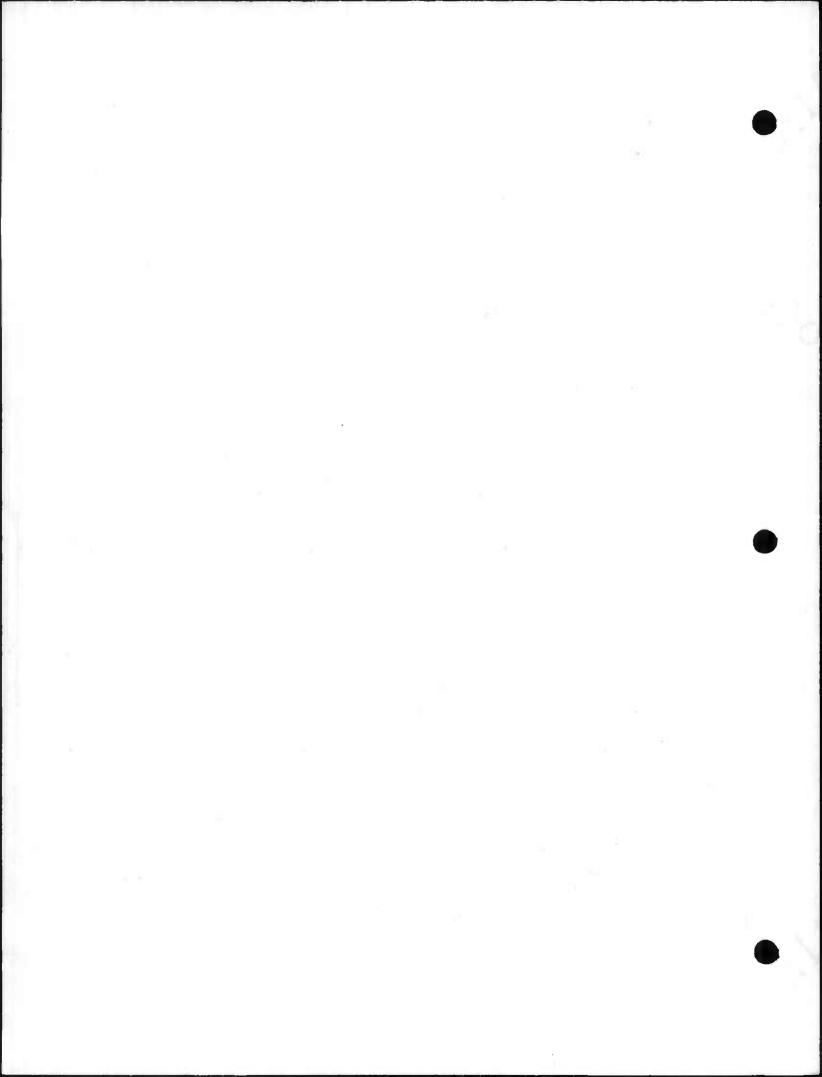
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RECORDS, P.O. BOX 68760	certificate
S, D	death
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<b>E</b>	that
3ECC	PALITOR
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Z	P.
OF VITAL	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed with
DIVISION	ATTENDING
	OB
_	HOSPITAL
	THE

										9	5 1	8745
	1 - FOR STATE REGISTRAR	STATE OF M					HEALTH AND	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH			3. TIME OF DEATH
	PAUL RAYMOND WI	LSON						MON	ün 1,	1995	YEAR	10:10 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:	st birthday)	IF UNDE	R 1 YEAR	IF UNDER 24 HRS	. 7. DAT	E OF BIRTH		0. BIRTHP	LACE (State or Foreign
	723-07-9722	1 🕅 M 2 🗆 F	69	YRS.	MONTHS	DAYS	HOURS MIN.	7 Mor	1, 19	26	Country)	MD
1	9a. FACILITY NAME (If not institution, give atre	et and number)	05		9h. CIT	Y TOWN	OR LOCATION OF		1, 15.		INTY OF DEA	
Œ	47 BLACKISTON AVE	ENTIE				MBER		232411			LEGAN	
DIRECTOR	RESIDENCE OF DECEDENT											-
H.	10a. STATE 10b. COUNTY	10b, COUNTY 10c, CITY, TOWH OR LOCATION									1	IOd, INSIDE CITY LIMITS?
	MD Allec	gany		Cu	mber	land	l					YES 2 NO
FUNERAL	10e. STREET AND NUMBER					10	f. ZIP CODE			10g. CIT		IAT COUNTRY?
E	47 Blackiston Ave	enue					21502			US	A	
5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	RMED	13.	WAS DEC	CENDENT OF HISE	PANIC ORIG	IN? (Specify Yes	or No-	14. RACE -	- American Indian,
	. 22	IF YES, GIVE W		NO		If yes, sp	ecity Cuban, Max 2 X NO Spe	icen, Puerto	Rican, etc.)		Black,	White, atc.
BY	3 Widowed 4 Divorced	Korea	ın					,			W	hite
8	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DE	CEDENT'S	USUAL C	OCCUPATION OF	ON of wadding	16	b. KIND OF BUS	SINESS/INI	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +	) life	. Do NOT u	se retired.)	)	ost of working					
P P	12		R	etire	ed				Railr	oad		
COMPLET	17. FATHER'S NAME (First, Middle, Last)	-					18. MOTHER'S	NAME (First,	Middle, Malden	Sumame)		
BE (	Raymond Guy Wi	lson					Cath	nerin	e (Nixo	on)		
6	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	and Number or Run	al Route Nui	nber, City or Town	n, State, Zij	p Code)	
F	Earl M. Wilson		3	6 San	nerv:	ille	Avenue	; Cum	berland	d, M	215	502
	20s, METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remov	14	20b. PLACE	ANDDATE	OF DISPO	SITION (Na			- T		City or Tow	n, Steta
	4 Donation 5 Other (Specify)	al from Stata	Mary	land	Vete Vete	erans	s Cemete	erv06	/05 Fl	ints	tone,	MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		Λ.	22	. NAME A	ND ADDRESS OF	FACILITY				
	Scarpelli Funeral Home											
-	100119400	ARK	WHI	elli		Cumb	erland,	MD	21502			
	23. PART I. Enter the diseases, or co shock, or heart fellure. Li	at only one cou	se on each line	eath. Do i	101 ente	r the mo	de of dying, a	uch aa ca	rdiec or reapi	ratory ar	reat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition											Onset and Death
	reaulting in death) a.		cioscle			art I	Disease					20 years
		DUE TO	OR AS A CONSE	OUENCE O	F):							
N	Sequentially list conditions,											
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSE	QUENCE O	F):							
5	CAUSE (Disease or Injury C.	DUE TO	OR AS A CONSE	OUENCE O	D.							
Ē	that initiated aventa reaulting in death) LAST	552 10	ON AD A CONSE	OULINCE O								į _
CEI	d.											
	PART II. Other aignificant conditions	contributing to	death but not	reculting	In the u	nderiyin	g ceuse given	in Part i.	24a. WAS AN			VERE AUTOPSY FINDINGS
MEDICAL	Chronic Obstruct	ive Puln	onary I	isea	se				PERFOR	~		WAILABLE PRIOR TO COMPLETION OF CAUSE
191									1	Z		OF DEATH?
2	DID TOBACCO USE CO	ONTRIBUTE	TO CAUS	SE OF	DEA.	TH Y	ES N N	0 [			-   '	
A	25. WAS CASE REFERRED TO MEDICAL	PICINIDOIL	10 0/100	, L OI			LACE OF DEATH		onel	_		
Sic		HOSPITAL:	FR/Outpetlent 3	□ noa	OTHE	R:	21					
PHYSICIAN:	1   1   1   1   1   1   1   1   1   1											
	all 1 V INSTURN 3   Princino											
ВУ	2 Accident Investigation 28s PLACE OF IM HIDTY — At home form of control factors office and a control factors of the control factors of t								ute Number			
	4 Homicide 6 Could not be	building,	etc. (Specify)			2, 2		Cit	y or Town, State)		surrett F101	
COMPLET	29e. CERTIFIER											
MP	(Check only											
00		THE DESIGN OF SX	arminion and/or	HTV#STIGSTIC	ni, in my	opinion, d	estn occured at t	ne time, de	e end pleca, an	d due to ti	he ceuse(s)	and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE N	IUMBER				Wonth, Day, Year)
0	Sear m						D09157			▶ 3	June 1	L, 1995

TO B ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul Snow, 124 W. 3rd Street; Cumberland, MD 31. DATE FILE UNIV. 0" 2" 1995

21502 32 REGINARIE SIGNATURE

DHMH-16 Rev 1/89

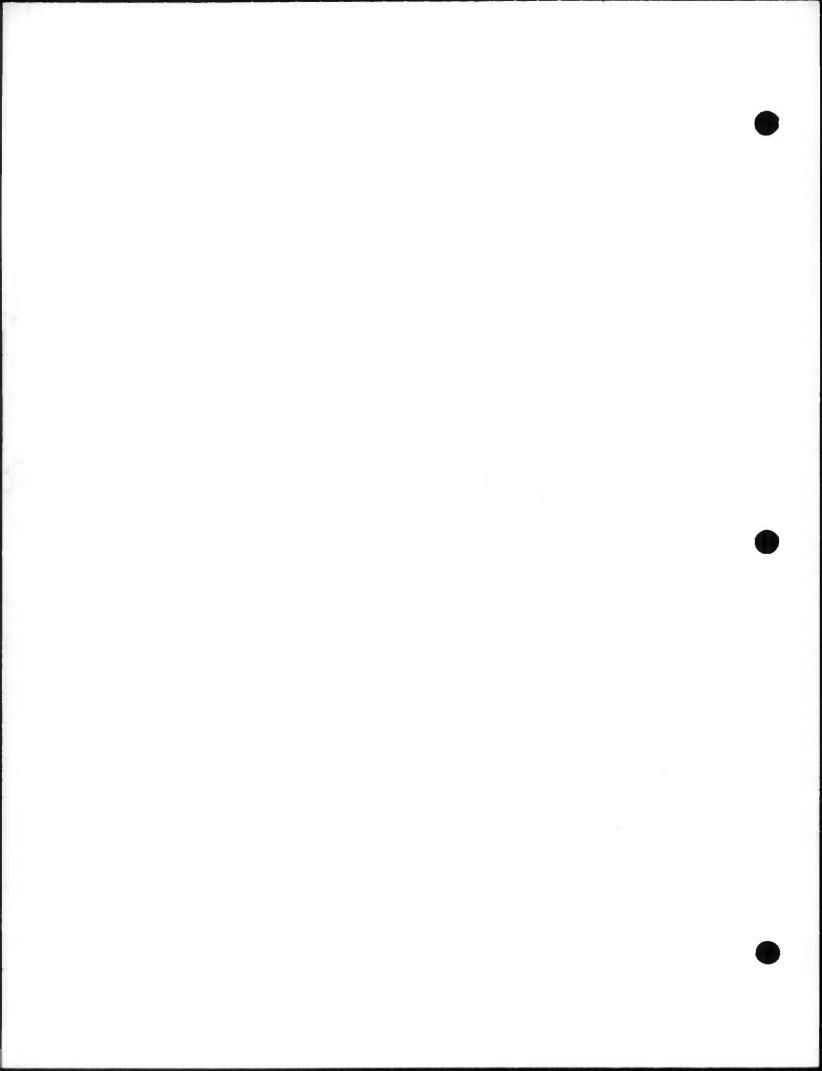


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled of the retained by the beautificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	ITMENT OF I	HEALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN	
	ROY BRANSON	WRACH				MAY 27	<sup>MY</sup> 1995 <sup>Y</sup>	6:00 A.M.	
	4. SOCIAL SECURITY NUMBER 220-10-7634	1 🖾 M 2 🗆 F 7	(In yrs. last birthday) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	JAN 16 19	18	BIRTINPLACE (State or Foreign Country) W.VA.	
œ	Sa. FACILITY NAME (If not institution, give s				OR LOCATION OF D	EATH	9c. COUNTY		
515 WINIFRED ROAD CUMBERLAND ALLEGA								GANY	
DIRECTOR	MADVI AND ATTECANY CIMPEDIAND							10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	10e. STREET AND NUMBER			10	1. ZIP CODE		10g. CITIZER	N OF WNAT COUNTRY?	
ER	515 WINIFRED ROA	D			21502		U.S	.A.	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	N U.S. ARMED 2XXNO ATES	If yes, sp	CENDENT OF NISPA pecify Cuban, Maxico 22 NO Specification	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) fy:	a or No 14	RACE — American Indian, Black, White, atc. Specify: WHITE		
0	15. DECEDENT'S EDU (Specify only highest grade	ICATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	ISINESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT ut			141.			
MP	8		KELLY S	PRINGFIE	LD TIRE	CO TIRE	MANUF	•	
	17. FATNER'S NAME (First, Middle, Last)	D				AME (First, Middle, Melder	Sumame)		
B	ROBERT WRACHFOR	ע		1000000		LEWIS			
2	ELIZABETH WRACHFO	RD				MBERLAND M			
	20a. METHOD OF DISPOSITION	200	. PLACE AND DATE					or Town, State	
į,	1 Donation 5 Other (Specify)		UMBERLANI			29 1995 CU		ND MARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE 011		22. NAME A	ND ADDRESS OF FA	FUNERAL H	IOME		
10	To Tale of	10 Mills				TREET CUMB		MARVI.AND	
	23. PART i. Enter the diseases, or	complications that caused List only one cause on a	d the death. Do r					t, Approximata	
	IMMEDIATE CAUSE (Finel		ech line.					Interval Between Onset and Death	
	disease or condition resulting in death)	C V A		ONSEQUENCE OF):					
_1		SENIL DI		1 YEAR					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSCOUENCE OF):								
S	cause. Enter UNDERLYING	c.							
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):					
ER	resulting in death) LAST	d							
AL C	PART II. Other algolificant condition	ne contributing to death b	ut not resulting	In the underlyin	g cauaa given in			24b. WERE AUTOPSY FINDINGS	
2						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEL							~	OF DEATH?	
ż	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO [	UNCERTAI	N		_	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:					
₹	1 YES 2 NO	1 Inpetient 2 ER/Outs 26a. DATE OF INJURY	patient 3 DOA 26b. TiM			6 Other (Specify)			
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	YES 2 NO	28d. DEŞCRIBE NOW	INJURY OCCUR	ED	
BY	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY	— At home, farm, s			26f. LOCATION (Street	and Number or I	Rural Route Number.	
COMPLETED	4 Nomicide determined	building, atc. (Spec	cify)			City or Town, State,			
드 등	29a. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my know	ledge, death occurre	ed at the ilms, date	and place, and due	to the cause(a) and ma	nner as stated		
OM		R: On the basis of examination						Juse(a) end manner as stated.	
	296. SIGNATURE AND TITLE OF CENTIFIE	R			29c. LICENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)	
O BE	Ochalety	, fee			D 36766			14 28 1995	
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)				9	
ı	DR. VIK POONAI		STREET	CUMBERL	AND MARY	LAND 2150	2		
	31. DATE FILED (MONTH), W 1995	32. RIGISTRAR'S SIN	AH EIL						



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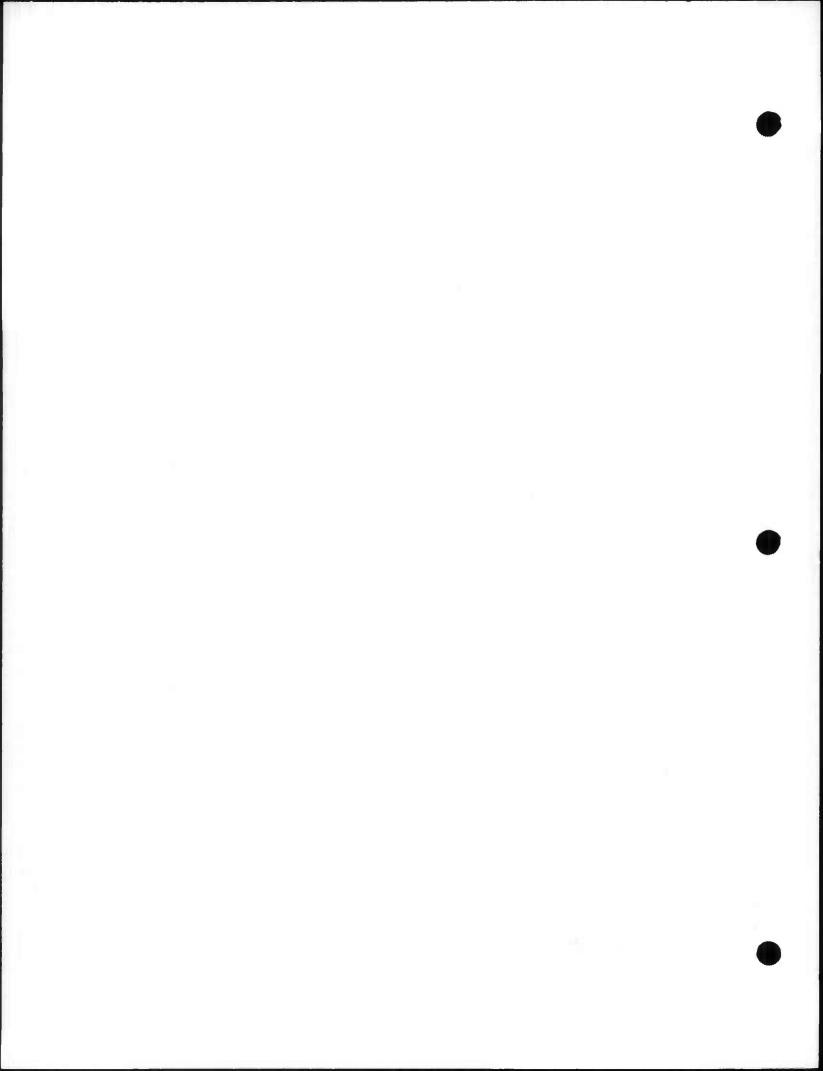
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. The hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE BEGISTRAR

	nedistran				U	ERIIF	ICAI	E U	DEA	I H		REG. NO.			
,	1. DECEDENT'S NAME (First, Middle, Lest)  DOROTHY LOUISE WA					DE				MONTH	MONTH DAY YEAR			3. TIME OF DEATH	
ł	HOULDIA												8:50 P M		
	218-16-3801 1 M 2 [		1 🗆 M 2 🖵 F	70 YRS.			MONTHS DAYS HOURS MIN.		(Month, DEC	(Month, Day, Year) DEC 16 1924		8. BIRTHPLACE (State or Foreign Country)  MARYLAND			
	9a. FACILITY NAME (If not ins MEMORIAL H	OSPITA					95. CITY, TOWN OR LOCATION OF DEA CUMBERLAND			EATH			EGANY		
F	RESIDENCE OF DEC	10b. COUNTY	,			10. 017	- manai	00.100							
	MARYLAND ALLEGANY					10c. CITY, TOWN OR LOCATION CUMBERLAND							10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	523 CAROLI	NE ST	REET					1	2150	_		109. CITIZEN OF WHA			HAT COUNTRY?
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced  12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR			T EVER IN				in, Maxica	n, Puerto R	(Specify Yes ican, etc.)	or No—	Black,	- American Indian, White, etc.		
ı	15. DECE	DENT'S EDUC	CATION		16a. DE	CEDENT'S	USUAL (	OCCUPAT	ION		16b.	KIND OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0-12		College (1-4 or 5 +	,	life	P TI	e retired.		CO.	ng	SU	PERVI	SOR '	TELEP	HONE CO.
	17. FATHER'S NAME (First, Mic	ddle, Last)							18. MOT	HER'S NA	ME (First, M	iddle, Maiden	Sumama		
	RICHARD B		rT		_				MA	RIE	IMES			_	
	BOYD D. WA				5	b. MAILING 23 CA	ADDRES	S (Street INE	STRE	or Rural I	Number 1	or, City or Town	ARY	p Code) LAND	21502
	20a METHOD OF DISPOSITION 1 Aburiat 2 Cremation 4 Donation 5 Other	n 3 🗆 Remo	oval from Stata	20b. F	PLACE AND DATE OF DISPOSITION (Name of STATE OF										
- 10-	21. BIGHATURE OF FUNERAL BERVICE LICENSEE					22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME									
1	Note	0(.	enu				4	04 г	ECATI	IR S'	TREET	CIMBI	ZRT.A1	ND MA	RYLAND
i	anock, or heert fellure. List only one cause on each line.									Approximate interval Between Onset and Death					
	IMMEDIATE CAUSE (Finel disease or condition metalling in death)  MYOCARDI.				AL INFARCTION								30 MIN.		
	DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if eny, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):														
	cause. Enter UNDERLYIN CAUSE (Disease or injur		DUE TO	OR AS A O	ONSE	NIENCE OF									-
	that initieted events resulting in death) LAST	٠ ل.	DUE TO (OR AS A CONSEQUENCE OF):												
ı	PART II. Other significant conditions contributing to deeth but not resulting in the							the underlying ceuse given in Part I. 2			24s. WAS AN AUTOPSY		24b.	WERE AUTOPSY FINDINGS	
									_	PERFORMED?  1 YES 2 NO		- 1	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOPACCO LIS	E CONTE	DIDLITE TO CAL	ICT OF	DEA	TII VE		No. R	<b>7</b>						1 TES 2 NO
	DID TOBACCO US		CIBUTE TO CA			E OF DEAT			-	ERTAIN	1 1				
ı	EXAMINER?		HOSPITAL:				OTHE	R:							
L	27. MANNER OF DEATH		28a. DATE OF	INJURY	iem: 3	28b. TIMI			JURY AT	sidence	6 Other	(Specify)	LIURY OC	CUBED	
		ending restigation	(Month, De				URY M	1 [	YES 2	] NO			NJUHY OCCURED		
3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, term, a building, atc. (Specify)					treet, tac	tory, offi	:•			TION (Street a Town, State)	nd Numbe	r or Rural Ro	or Rural Route Number,		
1			CIAN: To the best of a												and manner as stated.
H	29b. SIGNATURE AND TITLE			0 -0 -0 -0								mo piaca, and			
L	Wille	w	alm	no	W	10				5406				lay o	Month, Day, Year) 26, 1995
3	William La		D 47 W	irain	iio	A370		limb	erlan	d M	ID 21	1502		1	
3	11. DATE FILED (Month, Dry, Y		32. REGISTRAI	R'S SIGNAT	UDE	AVE.		, allin	LITAL	الا و الد	<u> </u>	102			
	MAY 3 7)	1932	The Commen												



STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

NINA

4. SOCIAL SECURITY NUMBER

LOUISE

5. SEX

WITT

6. AGE (In yrs. lest birthday)

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HOURS 1 M 2 X 214-16-2975 72 YRS. 19, Aug Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 1400 SOUTH WITT LANE DIRECTOR LAVALE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Allegany LaVale permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 1400 South Witt Lane funeral director, page 5 should be detached for use as the burial-transit 21502 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: В 3 📉 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EQUCATION (Specif Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Ħ Charles T. James Lavinia J. (Malcolm) BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Linda M. Heller 7621 McClellan Avenue; Boonsboro, MD hours after death. Page 6 may be pe 20e. METHOD OF DISPOSITION
143 Burisl 2 Cremetion 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Restlawn Memorial Gardens 05/30 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 n and completely filled in by the to bunal, cremation, or removal. the medical 23. PART/I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haert fellura. List only one cause on each line **IMMEDIATE CAUSE (Final** disease or condition resulting in death) 0 event, OUE TO (OR AS A CONSEQUENCE OF): executed rte traumatic Carcinna CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician and Health and Mental Hygiene prior to if any, leading to immediata death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? the MEDICAL requires that any 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO & PHYSICIAN: AM. certificate has be the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: I YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 6 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY with t 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY Investigation ATTENDING 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide OR 29a. CERTIFIER 1 📈 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL WITHIN 72 h HOSPITAL TO THE HOSPITE
TO THE FUNERA
De filed within 72
IMPORTANT: 1 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George Breza, M.D. 912 Seton Drive Cumberland, MD 21502

132. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MAI

95 18748 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF CEATH 3. TIME OF OEATH 8:50 P 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1922 WV 9c. COUNTY OF DEATH ALLEGANY 10d. INSIDE CITY tX YES 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. white 16b. KIND OF BUSINESS/INDUSTRY Contracting 20c. LOCATION - City or Town, State LaVale, MD Approximata interval Between Onset and Death

DHMH-16 Rev 1/89

9

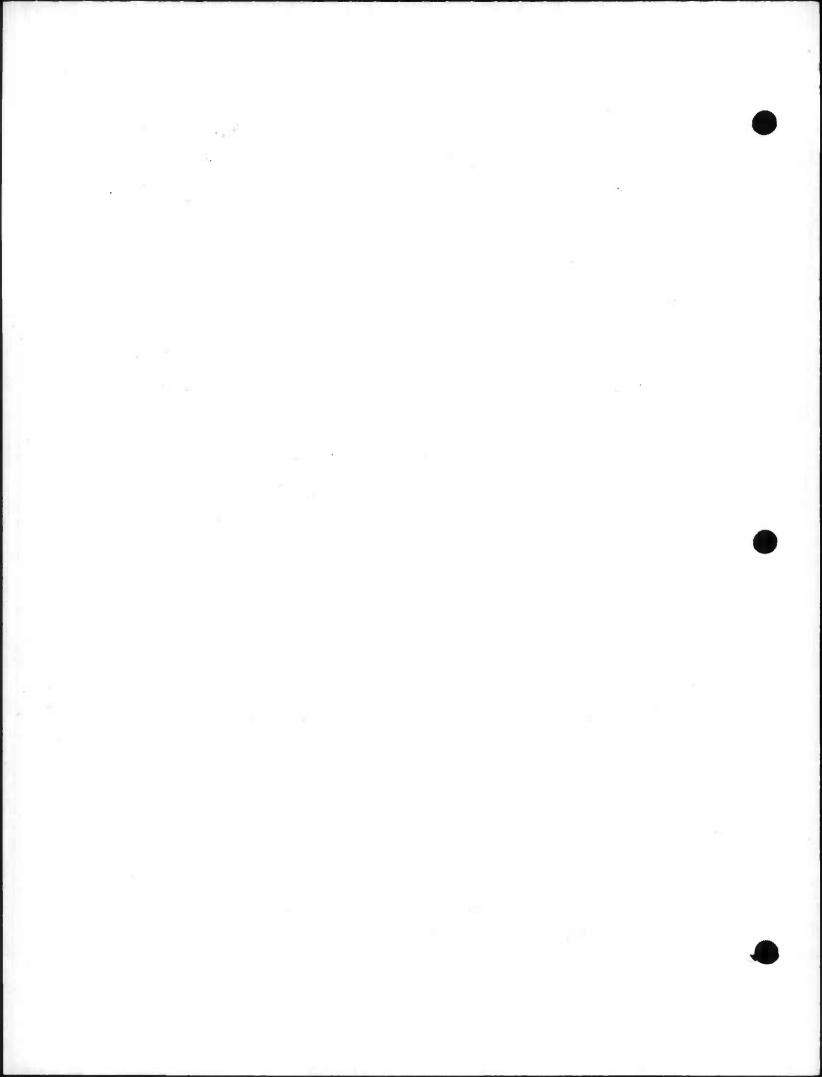
246. WERE AUTOPSY FINDINGS

WAILABLE PRIOR TO

1 TYES 2 T NO

29d. DATE SIGNED

COMPLETION OF CAUSE OF DEATH?

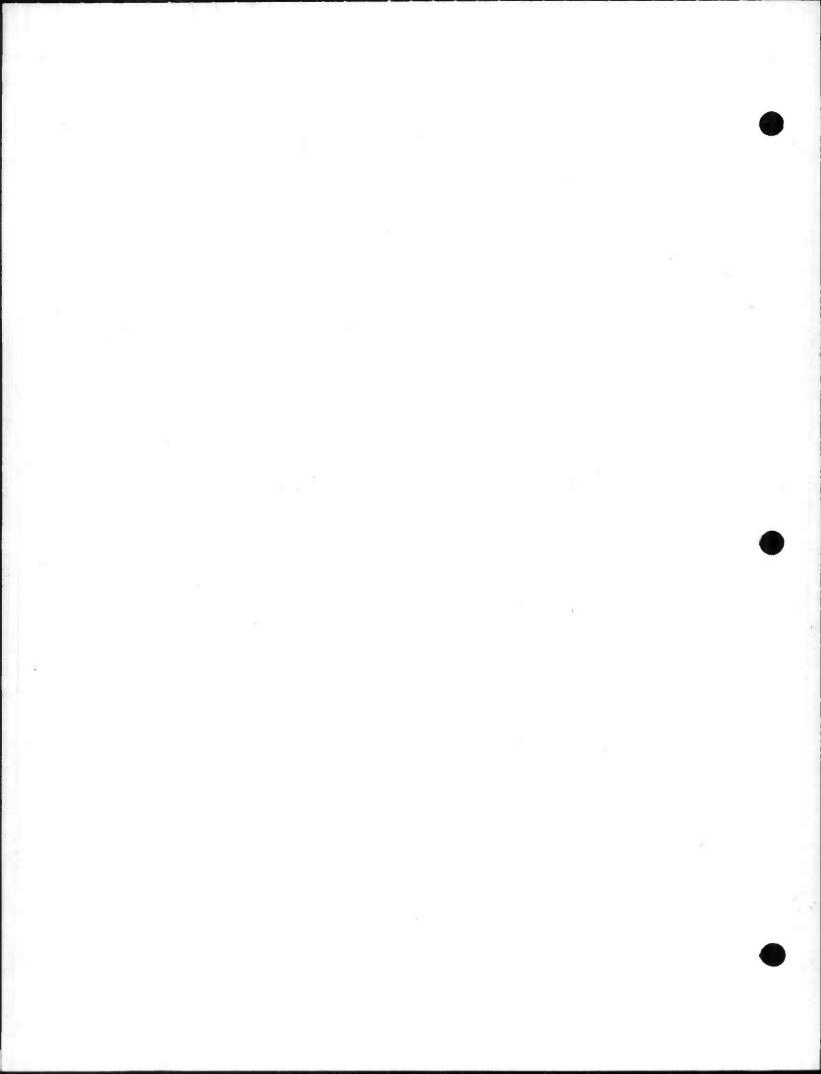


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral direct., page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Pages 1, 2, 3 should

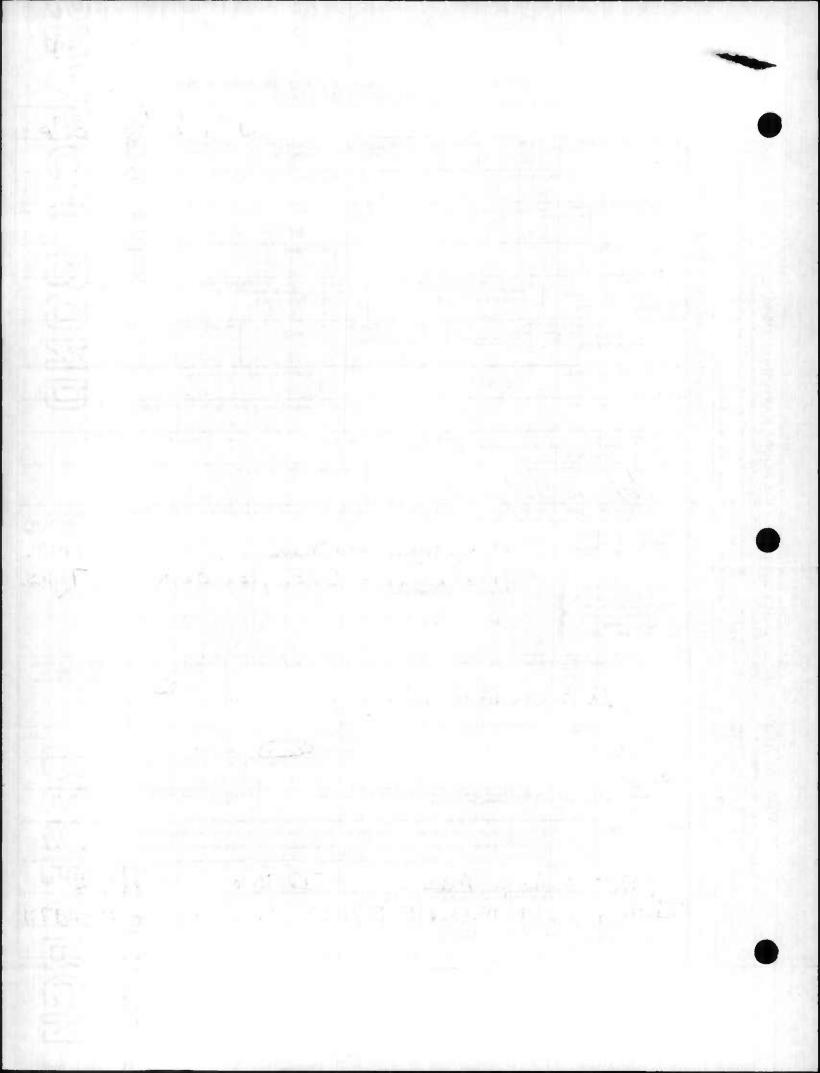
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIEN						
1	1. DECEOENT'S NAME (First, Middle, Last)			10/11/2 01	DEATH	2. DATE OF DEATH	).	_	3. TIME OF DEATH			
7	Hwa-Jung Yoo	n				May 19		995	3:00 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign			
- 0	216-25-9538	1 M 2 F	59 YRS.	MONTHS DAYS	HOURS MIN.	Feb. 4, 1	936	Countr	orea			
~	9a. FACILITY NAME (If not institution, give				OR LOCATION OF E	EATH	9c. COU	NTY OF D	EATH			
D O	3107 Hewitt Avenu	ue, Apt. 43/		Silver	Spring		Mon	tgom	ery			
DIRECTOR								19d.				
	Maryland Mont	gomery	Si	lver Spi	ing		1					
FUNERAL	10e. STREET AND NUMBER			10	f. ZIP CODE	10g. CITIZEN OF			WHAT COUNTRY?			
N.	3107 Hewitt Avenu				20906		USA :	Perm	. Resident			
	11. MARITAL STATUS  1 Never Married 2 X Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 MO	t3. WAS DE	ENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No—	14. RACE Black	— American Indian, t, White, stc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗆 YES	2 X NO Speci	ty:	Korean					
ED	15. DECEDENT'S EDU (Specify only highest grad	UCATION In completed	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b, KIND OF BU	SINESS/IND	USTRY	Rolean			
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	,								
COMPLETED	8	0	Self	-employe			Esta	ate				
	17. FATHER'S NAME (First, Middle, Last) Hui-Byung Yoon					AME (First, Middle, Malden	Sumame)					
BE	19a. INFORMANT'S NAME (Type/Print)		105 MAILING	ADDRESS (Danie)	Man-Ry	Route Number, City or Tow						
2	Jong-Joo Yoon								ing MD 20006			
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION // DATE 20c. LOCATION - City of Towns State											
	1 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from Stata cem	etery, crematory or o	ther place) Temorial	Park	5/23 01n	ev. M	[arv]	and			
	21. SIGNATURE OF FUNERAL SERVICE LI	ceptate //		22. NAME A	ND ADORESS OF FA	pshire Ave	inald	i Fu	neral Home			
	1 / Muly XX	unald		Silve	r Spring	, Maryland	nue 209	04				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between											
	IMMEDIATE CAUSE (Final											
	disease or condition Liver Cirrhosis								3 yrs.			
	DUE TO (OR AS A CONSEQUENCE OF):  Hepatitis B  DUE TO (OR AS A CONSEQUENCE OF):											
ON I												
S	cause. Enter UNDERLYING	Probable H	Hepatoma									
E	CAUSE (Disesse or injury that initiated events											
CERTIFICATION	resulting in desth) LAST											
	PART II. Other significant condition	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY FINDINGS										
PHYSICIAN: MEDICAL	None  None  PERFORMED?  1 □ YES 2 № NO								AMAILABLE PRIOR TO COMPLETION OF CAUSE			
ME									OF DEATH?  1 YES 2 NO			
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S 🗆 NO 🛭	UNCERTAI	N 🗆						
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:								
ΥS	1 YES 2 NO 27. MANNER OF DEATH	1   Inpatient 2   ER/Outp	atient 3 DOA	4 - Nursing Hon		6 Other (Specify)						
	1 Netural 5 Pending	(Month, Day, Year)		URY WO	RK?	28d. DESCRIBE HOW I	NJURY OCC	UREO				
) BY	2 Accident Investigation 3 Suicide 6 Could not be	2 Accident Investigation 3 Suicide 5 Could not be 26a. PLACE OF INJURY				26f. LOCATION (Street )	oute Number,					
1	4 Homicide datarmined	building, atc. (Spec	<i>ay)</i>			City or Town, State)			1.11.00			
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my knowl	edge, desth occurre	ed at the time, date	and place, and due	to the cause(s) and mar	nner as state	ed.				
OM		ER: On the beels of examination							and manner as stated.			
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NU				(Month, Day, Year)			
TO B	anch	11-6),			D1490	5	▶ May 23, 1995					
	30. NAME AND AGORESS OF PERSON WE											
	Year-Kwon H. Yoon 31. DATE FILEO (Month, Day, Year)	, M.D. /30/ B	altimore	Avenue	, #111,	College Pa	rk, M	aryl	and 20740			
	MAY 30 1995		Revell									
	11111 00 1333	4										



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6	has	200
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S	ertifi the	20
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NO.	NRE OUR	6
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retr	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 s be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked or Item 23 shows any Injury or other traumatic event the medical examinar must be not
SPI	NER hin	Ė
E HO	日本	PITA
H	上号	04
2	23	2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MEN	NTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARY		CATE OF DE		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	oy Yingli				2. DATE OF DEATH DAY	VEAR	3. TIME OF DEATH		
	Richard LeR		June 6	95	OP					
	213-24-8525	1 🛚 M 2 🗍 F	67 YRS.	ONTHS DAYS HOUR	MIN,	7. DATE OF BIRTH (Month, Day, Year) Feb. 9, 1928	B M	aryland		
TOR	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  190 Bucher John Rd.  Union Bridge  Ca									
DIRECTOR	Maryland 10b. count	v Carroll	TOWN OR LOCATION Union Br	aohir		10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER		101. ZIP CO		100	1 TES 2 NO				
FUNERAL	190 Bucher John	Rd.			21791		A.			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	IN U.S. ARMED 2 NO DATES	13. WAS DECENDEN If yes, specify Co	uban, Mexican,	ORIGIN? (Specify Yes or No Puerto Rican, etc.)	0— 14. RAC Blec Spec	E — American Indian, k, Whita, etc. #y: White			
COMPLEIED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S U: (Give kind of wo. life. Do NOT use	k done during most of wo	orking	16b. KIND OF BUSINES	S/INDUSTRY			
	Elementary/Secondary (0-12)	motor	tender		cement					
5	17. FATHER'S NAME (First, Middle, Last)			16. M	OTHER'S NAME	E (First, Middle, Melden Surne	me)			
BE	F. LeRoy Yinglin	g			Ida Be	elle Dodrer		THE REAL PROPERTY.		
2	19a. INFORMANT'S NAME (Type/Print)	1.				ute Number, City or Town, Ste				
	Catherine A. Ying			cher John	Rd.	Union Bridg				
	206. METHOD OF DISPOSITION 1   Burlel 2 D. Fremetion 3   Removel from State 4   Donation 5   Other (Specify)   Carroll Cremation, Inc.   6/10   Hampstead, MD									
	21. SIGNATURE FUNERAL SERVICE LICENSES OF FACILITY D. D. Hartzler & Sons Union Bridge, MD									
	23. PART I. Enter the diseases, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
	IMMEDIATE CAUSE (Final							Onset and Dec		
	disease or condition resulting in death)	· WISI	anoma	- 12ro		IMO				
	DUE TO (DR AS A CONSEDUENCE OF):									
	Sequentially list conditions, if any, leading to immediate Due to (on as a consequence of):									
2	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEDUENCE OF):									
CERTIFICATION	resulting in deeth) LAST									
MEDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO									
2	11/4 0 146	Cod police		- 12		1 TYES 2 NO				
Ś	25. WAS CASE REFERRED TO MEDICAL			28. PLACE DE	F DEATH (Checi	k only one)				
2	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		THER:	-	Other (Specify)		3-1-1-1		
PHYSICIAN:	27. MANNER OF DEATH  1 Nature 5 Pending	28a. DATE DF INJURY (Month, Day, Year)  28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURE (MORK?)								
ED BY	2 Accident investigation							nd Number or Rural Route Number,		
COMPLEIED	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
BE	296. SIGNATURE AND TITLE OF CERTIFIES		1		ICENSE NUMB			(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WH	D COMPLETED CAUSE OF DE	EATH (HEM 27) (Type P	DILLAC	Uln	Ivan Bui	Ne	1120176		
	3" JUN 9"1995" July	de William St.	DURE	- 61.10			7)			



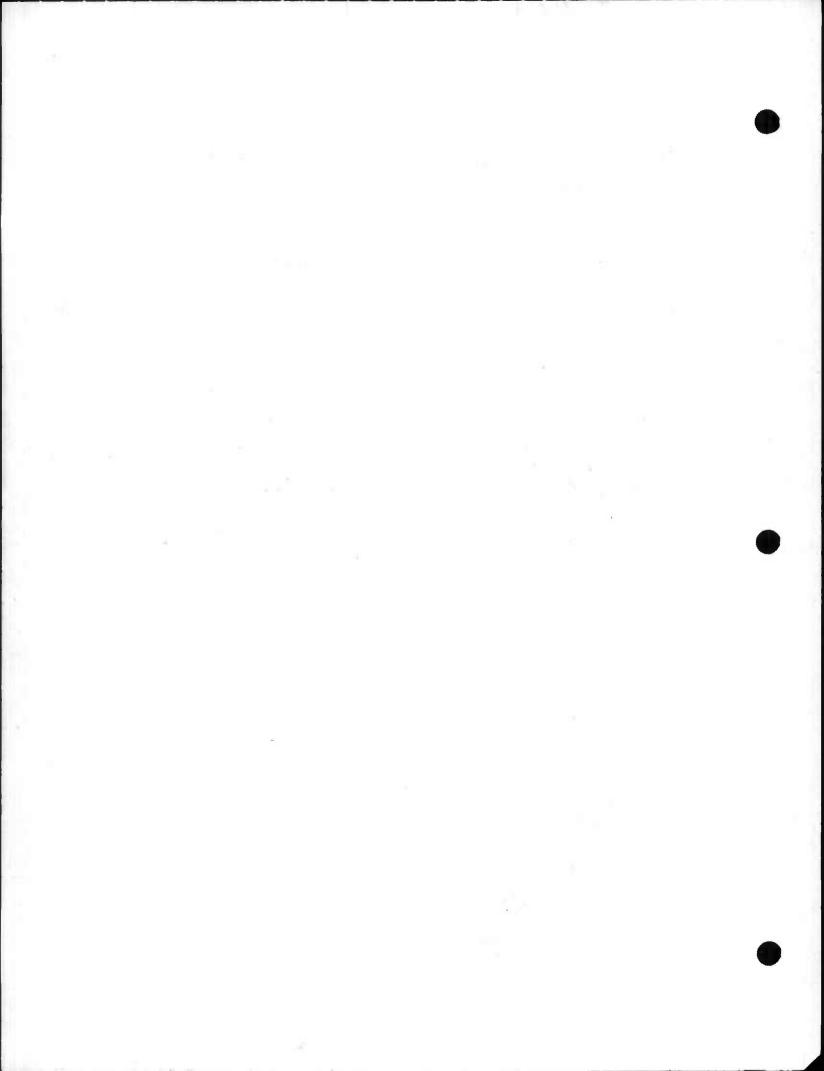
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		t. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY	Y YEAR	3. TIME OF DEATH		
	Ethel Zo	Ouppas  5. SEX  6. AGE (In yrs. last birthday)   F UNDER 1 YEAR   F UNDER 1				5 29 - 9572 3				
	214-08-7426	1 □ M 2 🖾 F		NTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)  Mar. 14, 1	Cou	NTHPLACE (State or Foreign Intry) .bania		
	Se. FACILITY NAME (If not institution, give	street and number)		city, town o	OR LOCATION OF DEA		9c. COUNTY OF			
08	926 Chart Court			Lusby			Calve	rt		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUN	ITY	10c. CITY, TO	OWN OR LOCAT	ION		tod. INSIDE CITY			
5	Maryland Cal	Maryland Calvert					t YES 2 NO			
FUNERAL	10e. STREET AND NUMBER 926 Chart Court			1.0	ZIP CODE		10g. CITIZEN OF WHAT CO			
N	11. MARITAL STATUS	12. WAS DECEDENT EVER I	20657				USA			
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Mexican, 2 X NO Specify:	ORIGIN? (Specify Yes- Puerto Rican, etc.)	94	ACE — American Indian, ack, White, etc. ec/ly: White		
TED	15. DECEDENT'S EC (Specify only highest gra	DUCATION de completed)	16a. DECEDENT'S USI	done during mo	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY			
COMPLET	Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	iii. Do NOT use re Homem			Own 1	II.			
<b>№</b>	17. FATHER'S NAME (First, Middle, Last)		пошен	aker	18. MOTHER'S NAME	E (First, Middle, Maiden S				
BE C	Sokrates Kopos					ria Gwvou	,			
0	19e. INFORMANT'S NAME (Type/Print)					ute Number, City or Town.		Zip Code)		
	Nicholas Zouppas	100				, Maryland				
	t ⊠ Burlet 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	place anodate of dietry, cremetory or other Gate of He	place) AVED C.	emeterv		eation - City or	ng, Maryland		
	21. SIGNATURE OF FINERAL SERVICE	walk.		22. NAME AN 1180(	New Hami	wHines-Ripshire Ave Maryland	naldi E nue	Tuneral Home		
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec o shock or heart failure. List only one cause on each line.								Approximate		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Chronic Aynghatic Roukemia Sever									
	DUE TO (OR AS A CONSEQUENCE OF):									
RTIFICATION	Sequentially list conditions, If any, leading to immediate									
3	Cause, Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
	d									
4	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PINDINGS PRICORMED?  ANALABLE PRICOR TO									
MEDIC						1 TES 2	100	OF DEATH?		
	DID TOBACCO USE CON	TRIBUTE TO CAUSE C	E DEATH YES	I NO IT	UNCERTAIN	<u>-</u>		1 Tes 2 No		
A	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C	Check only one)	ONCERIAIN	1				
PHYSICIAN:	1 VES 2 NO	HOSPITAL: 1   Inpetient   2   ER/Outp		THER:  Nursing Home	5 Mealdence 8	Other (Specify)				
	27. MANNER OF DEATH  1 Natural 5 Pending	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	WO	URY AT 2 RK? 'ES 2 NO	8d. DESCRIBE HOW IN	JURY OCCUREO			
BY BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, ferm, stree			8f. LOCATION (Street an	nd Number or Rura	I Route Number,		
ED	4 Homicide dstarmined		eny)			City or Town, State)				
MPLE	290. CERTIFIER (Check only	SICIAN: To the best of my know	ledge, death occurred at	the time, deta	and place, and due to	the cause(s) end mann	ner as stated.			
200	one) 2 MEDICAL EXAMI	NER: On the basis of examination	n end/or investigation, in	n my opinion, de	eath occured at the tin	ne, date and place, and	due to the cause	e(e) end menner ee stated.		
O BE	296. SIGNATURE AND TITLE OF CERTIFI	M.D Alle	nding	Physi		427	> 5	29 95		
	30. NAME AND ADDRESS OF PERSON W	LRD PR	ATH (ITEM 27) (Type Prin	RED	ERICIC	MARY	1641	D20678		
	JUN 01 1995	The Sander	Rardall							



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	4073623 2000480 . John	04/01/	7 1						17		
	CIN N 75 5 6	1112						9.5	1	8752	
	12152 NEBEDIA	N DEI AE						2 0	1	0702	
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI	RTMENT	OF HEALT	HAND					
	1. OECEDENT'S NAME (First, Middle, Last)		OLIVIII	IOAIL	OF DEA	VIII.	REG. NO.		T	3. TIME OF OEATN	
	John Zuccaro						монтн Мау 27, 1	995	YEAR	10:10 P. M	
	4. SOCIAL SECURITY NUMBER 377-14-8955	5. SEX 6. AGE	(in yrs. fast birthday)	IF UNDER	1 YEAR IF UND	ER 24 HRS. MIN.	(Month, Day, Year) Country				
	9a. FACILITY NAME (If not institution, give	21	75 YRS.	9b. CITY.	TOWN OR LOCAL	TION OF OF	Dec. 2, 19	_	Italy		
OR O	Montgomery Genera			01ne					gome		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNT		10c, CI		R LOCATION					10d. INSIDE CITY	
DIR	Maryland Mont	gomery		wood						LIMITS?	
IAL	10a. STREET AND NUMBER				10f. ZIP CO	OE		10g. CITI		AT COUNTRY?	
FUNERAL	19728 Meredith Dr				208					tates	
	1 Never Married 2 📉 Married	12. WAS DECEDENT EVER I FORCES? 1 TY YES IF YES, GIVE WAT OR D	2 NO	- 11	yes, specify Cut	oan, Maxica	HC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No-		- American Indian, White, etc.	
ЭВУ	3 Widowed 4 Divorced	1941 -			☐ YES 2 💢 NO	э эрөслу	r.		Specify	White	
TE	15. OECEDENT'S EDI (Specify only highest grad	e completed)	18e. DECEDENT'S (Give kind of life. Do NOT u	work done d	CUPATION luring most of work	king	16b. KIND OF BUS	SINESS/INC	DUSTRY		
IPLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Accou			Fairchi			ld Industries		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Mald					den Surname)			
BE	Cataldo Zuccaro  190. INFORMANT'S NAME (Type/Print)		Giuseppina Agostini								
5	Lucy J. Zuccaro			196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19728 Meredith Drive, Derwood, Maryland 20855							
	20a, METHOD OF DISPOSITION 1 (X Burial 2 Cremation 3 Rem	201	. PLACE AND DATE	OF DISPOSI		ive,			City or Tow		
	4 Donation 5 Other (Specify)	∠ G	netery, crematory or cate of H	eaven				ver S	Sprin	g, Maryland	
8	21. SIGNATURE OF FUNERAL SERVICE	DENSEE		22. N	Vol Fun	ess of face	Home				
	7.()	5-4-		10	E. Dee:	r Par	k Dr., Gai	ther	sburg	, MD 20877	
	\ /	List only one ceuse on e	d the death. Do ach line.	not enter i	the mode of d	ying, suci	h aa cardiac or respi	ratory arr	rest,	Approximate interval Between	
	disease or condition resulting in death)	stone a	n C O M	la lu	1				Onset and Death		
	resulting in death)	B. Mulli Su DUE, TO (OR AS		/	)	1.				30dap 60dp	
ATION	Sequentially list conditions,	b. SLASS	CONSEQUENCE O							60dp	
	if any, leading to immediate cause. Enter UNDERLYING	pulna	/						60 days		
FI	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE O	PF):						10yeas	
CERTIFIC	resulting in deeth) EAST	a Crokers C	disease.							10years	
	PART ii. Other significant condition	na contributing to deeth b	ut not resulting	in the unc	derlying cause	given in	Part i. 24s. WAS AN A			VERE AUTOPSY FINDINGS	
MEDICAL							1 YES 2			COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE CONT	DIDLITE TO CALISE C	E DEATH V		10 🗆 1111	CEDIAN			1	☐ YES 2 ☐ NO	
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			CERTAIN	1 LJ				
PHYSICIAN:	1 YES 2 YO	HOSPITAL:	eatlent 3 DOA	OTHER		lesidence	8 Other (Specify)				
	27. MANNER OF DEATH  1 Metural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF S	28c. INJURY AT WORK?		28d. DESCRIBE NOW IN	JURY OCC	URED		
ВУ	2 Accident Investigation	28s. PLACE OF INJURY	- At home, term,	street, facto		YES 2 NO  **Rea 28f. LOCATION (Street and Number or Rural Route Number,				ste Mumber	
TED	4 Homicide 8 Could not be determined	olfy)		,,		City or Town, State)	no reamour	or norm noc	ne Namber,		
COMPLET		ICIAN: To the best of my know									
SON	2 MEDICAL EXAMINI	ER: On the basis of examination								and manner as stated.	
BE (	296. SIGNATURE AND TITLE OF CENTIFIE	0				ENSE NUM	BER			Aonth, Day, Year)	

30. NAME AND ADDRESS OF PERSON WING COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

MARTIN M

32. REGISTRAR'S SIGNATURE

Julia Diwelson-Randall

DHMH-18 Rev 1/89

- Danis (56) City dus is

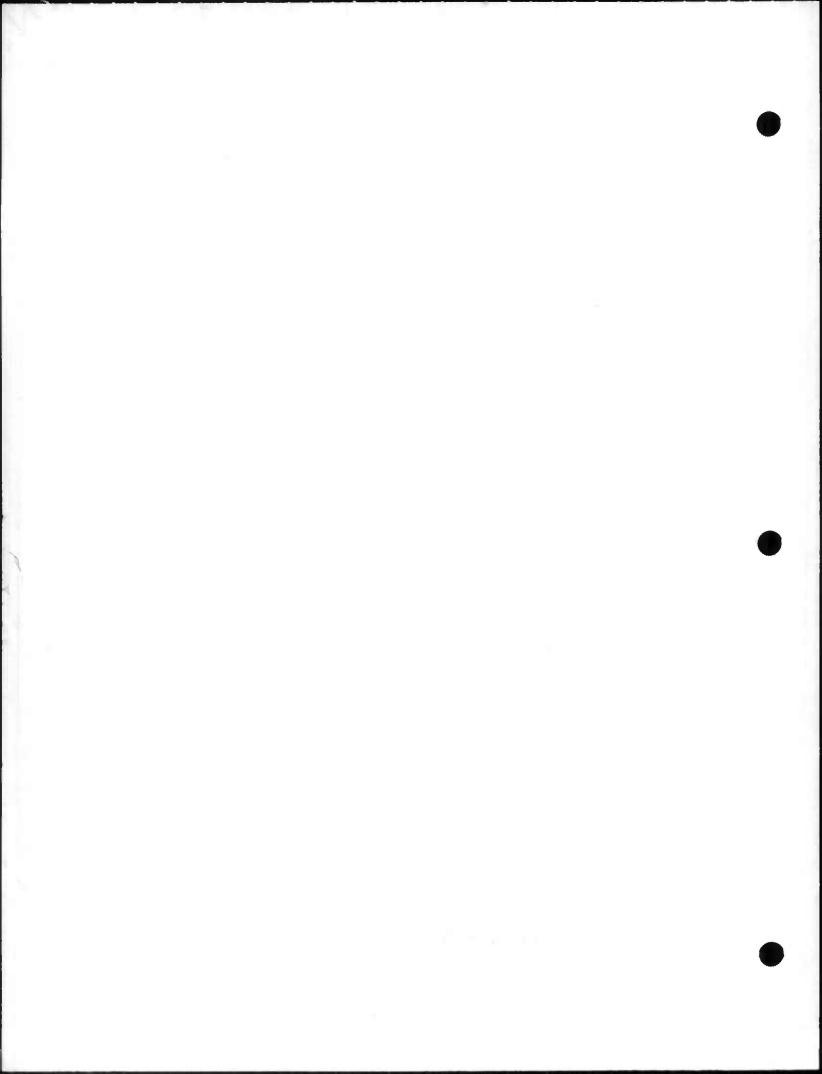
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHYSICIAN. The law renuires that the death certificate he executed within 3 hours after death. Pans 6 may he retained by the honories or strategies in the control of the c	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within the State Best, or Pleath and Mental Hones prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE MEDITAL OR ATTENDED PHYSICIAN: The law requires the	TO THE FUNERAL DIRECTOR: After this certificate has been signed be filed within 72 hours after death with the State Deor. of Health	IMPORTANT: If item 28 is marked, or item 23 shows an

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			ERITE	ICATE	OF	DEATI	Н	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Leat)  LAWRENCE ZELENY	7							2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. i	lant histoday)	Æ IMPER	4 WEAR			May	27,	15	95	1:20 P M
1	215-44-8738	91	MONTHS DAVE MONTHS ANN					7. DATE OF BIRTH (Month, Day, Year) April 30, 1904 Minnesota			77/		
	9e. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	, TOWN C	R LOCATION	N OF DEAT	TH		9c. COL	INTY OF E	DEATH
FUNERAL DIRECTOR	Washington Adventist Hospital					oma	Park				Mor	tgom	nery
Ä	10e. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
	Maryland Princ	e George	S	Uni	vers		Park				LIMITS?		
ERA	4312 Van Buren St	reet				1000	. ZIP CODE . 0782			-	U.S.A.		
3	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. /	ARMED	13.			HISPANIC	ORIGIN? (S	pecify Yes		7	E — American Indian,
B	t Never Merried 2 Merried  3 X Widowed 4 Divorced	FORCES? 1 [ IF YES, GIVE WA	YES 2 X	ОиО		If yes, sp	city Cuben,	Maxican, Specify	Puerto Rice	n, etc.)		Spec	k, White, etc.
9	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)		DECEDENT'S (Give kind of	vork done i	CCUPATIO	N st of working		16b. Kill	ID OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (t-4 or 5+) 5+	- 4	no noru	se retired.)				Und	+04	Ctot		Government
OM	17. FATHER'S NAME (First, Middle, Last)	<i>J</i> 1	1 00	real	Chem	ISL	16. MOTHE	R'S NAME	E (First, Midd			es G	overnment
BE C	Anthony Zeleny						Matt			.,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
TO B	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	AODRESS	(Street a	nd Number o	r Rural Ro	ute Number, (	City or Town	, State, Zi	p Code)	Ma
F	Nancy Kuhn			4204	Flow	er V	alley	Dri	lve, F	lockv	ille	, MD	20853
	20e. METHOD OF DISPOSITION  1 N Burial 2 Cremetion 3 Rem  4 Donation 6 Other (Specify)	oval from State	cemetery, of	eand date of contract of the c	In C	eme	ery (	05/30	0/95	Bren	two	od. N	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	01		22. Fr	NAME AN	D ADDRESS	OF FACIL	UTY S SOT	c Fu	noro	1 По	me, P.A.
	Skarles F	Bell	1	× .	4	739	Balti	more	Ave.	, Hy	atts	vill	e, MD 20781
NC	ahock, or heart failure.  IMMEDIATE CAUSE (Fine) disease or condition resulting in death)  Sequentially, list conditions	DUE TO	OCAA	EQUENCE OF		NF	ART	TON	•				Interval Between Onset and Death
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
	PART II. Other aignificant condition	s contributing to d	leath but not	resulting	n the un	derlying	ceuse glv	ven in Pa	nrt i. 24	. WAS AN		24b	. WERE AUTOPSY FINDINGS
EDICAL									_   10	PERFORI			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
필									_ /	/			1 YES 2 NO
ÿ	DID TOBACCO USE CONTI	RIBUTE TO CAU	ISE OF DE	ATH YE	s 🗆 t	10 E	UNCE	RTAIN	0				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEAT	H (Check o								
XSI	1 TYES 2 NO	1 Dispatient 2 -		3 DOA			5 🗆 Rasio	dence 6	Other (Sp	ecify)			
- 4	27. MANNER OF OEATH  1 Netural 5 Pending Investigation	E OF URY M	26c. INJI WO 1   Y			28d. OEŞCRI	BE HOW IN	JURY OC	CURED				
26e PLACE OF IN HIRY — All home form street feature office								Route Number,					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE	CIAN: To the best of m											e) end manner ae stated.
TO BE	290. SIGNATURE AND TITLE OF CERTIFIER  SO, MAME AND AIRCRESS OF PERSON WH	Mour O COMPLETED CAUSE	Sher OF DEATH (IT	EM 27) /5pm	Pointi	<	1) H	SE NUMBI	96		29d. DAT	S J )	(Morth, Day, Year)
	JUN 01 1995	32. REGISTRAR	SIGNATURE		-			<del></del> ;					



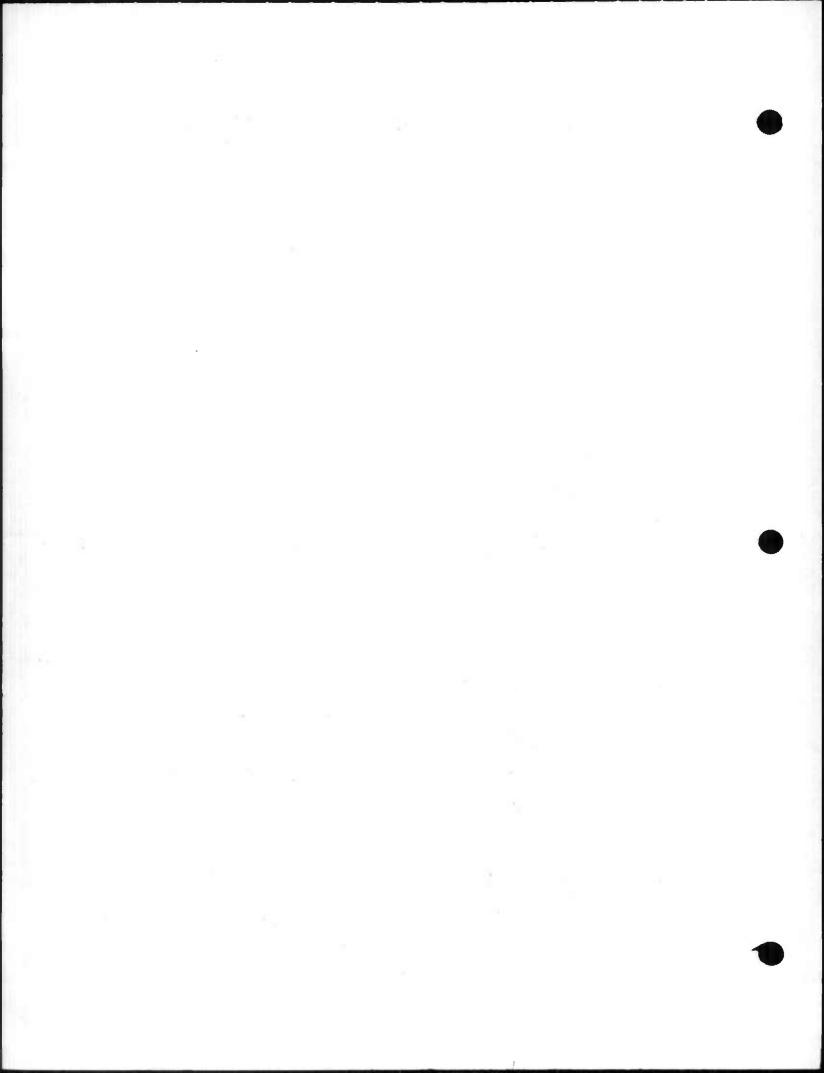
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PMYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	consecut, to removal.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1sh filed untiting 27 hours after death with the Case One of Health and Manual Mariana prior to build accomplished in the Case of Health and Manual Mariana prior to build accomplished in the Case of Health and Manual Mariana prior to build accomplished in the Case of	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, MONIE 424 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HR B. BIRTHPLACE (State or Foreign 1 M 2 K F DAYS HOURS 014-05-5515 88 August 27,1906 Poland 9e. FACILITY NAME (If not institution, give street end number) oc. COUNTY OF DEATH Prince George's 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR Southern Maryland Hospital Center Clinton County RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION County 10d. INSIDE CITY Maryland Prince George's Clinton 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States 11406 Accolade Court 20735 of America 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 ☐ Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surnar John Press Stella UNAVAILABLE BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Walter Zuck 11406 Accolade Court, Clinton, MD 20735 00. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 80177 1X Burlel 2 Cremetion 3 Removal from State netery, crematory or other place)
Stanislaus Cemetery Donation 5 Other (Specify) St. 1995 Chicopee, Massachusetts 21. SIGNATURE OF FUNERAL SERVICE LICENSER 22. NAME AND ADDRESS OF FACILITY #M00690 KOZIKOWSKI FUNERAL HOME 01013 JOU 565 Front Street, Chicopee, Massachusetts 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition will complications Yachur resulting in death) DUE TO (OP AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART N. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? On hero polistic apple Viscolar drease 1 YES 2 NO Julmoney 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO TO UNCERTAIN 1 PHYSICIAN: 25. WAS CASE DEFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA ome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 1 Netucel -20м 1 YES 2 NO ВУ 2 Accident 28e, PLACE OF INJURY 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know viedge, death occurred at the time, date end place, end due to the car 2 MEDICAL EXAMINER: On the nation end/or investigation, in my opinion, death occured at the lime, date 296, SIGNATURE AND TITLE OF CERT LICENSE NUMBER BE 2

> 32 REGISTRAD'S SIG Davidson Randall

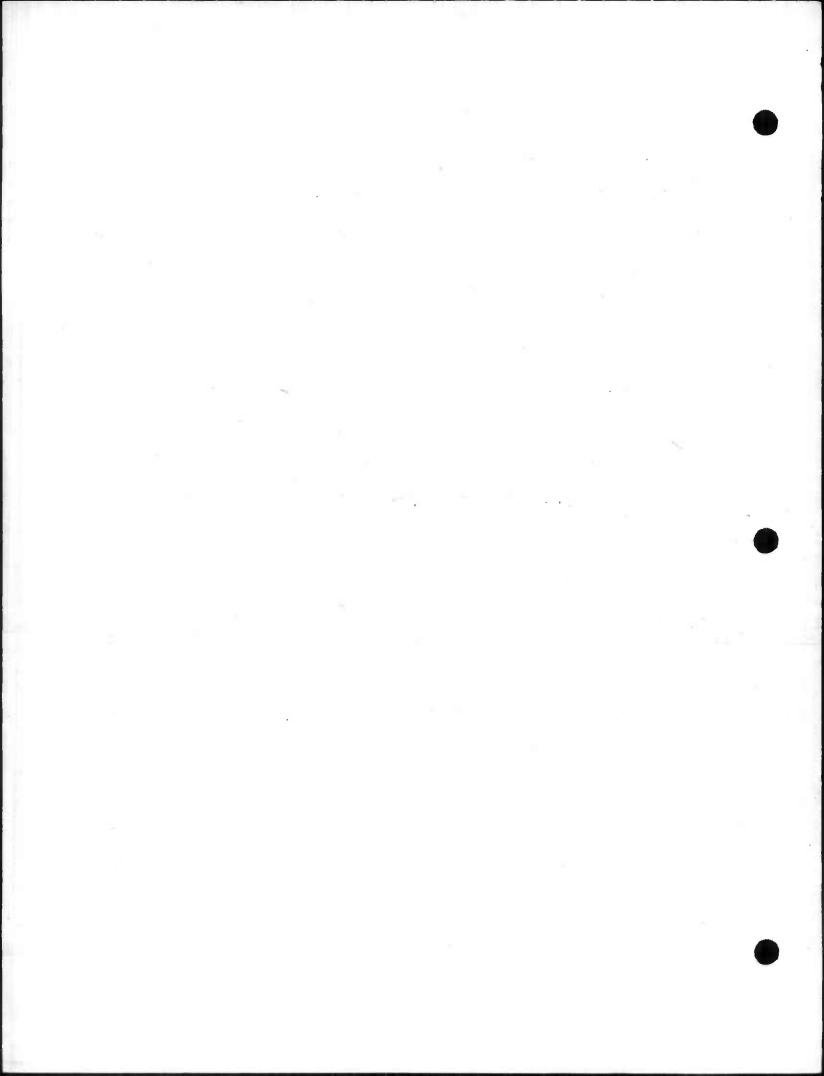


BALTIMORE, MARYLAND 21215-0020

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THE PRINCES OF CHILDREN AND AND ADMINISTRATION OF THE PROPERTY
be filed within 72 hours after death with the State Dept. of Hearth and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.					
9.	1. DECEDENT'S NAME (First, Middle, Last)  WILLIAM	BOHME.	R	2. DATE OF DEATH DAY	YEAR 12:10 A M				
	4. SOCIAL SECURITY NUMBER 5. SEX 218-42-8868 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 90 YRS. MC	F UNDER 1 YEAR IF UNDER 24 HRS.  ONTHS DAYS HOURS MIN.	2/12/1905	B. BIRTHPLACE (State or Foreign Country)				
HOL:	se. FACILITY NAME (If not institution, give street end numb Church Hospital RESIDENCE OF DECEDENT	9(	Baltimore		Y OF DEATH				
DIRECTOR	MD 106. STATE	10c. CITY, 1	Baltimore	Baltimore City					
FUNERAL	100. STREET AND NUMBER 127 N. Lakewood Ave.		10f. ZIP CODE 21224						
B	1 Never Married 2 Married FORCES	CEDENT EVER IN U.S. ARMED 7 1 YES 2 NO SIVE WAR OR DATES	13. WAS DECENDENT OF HISPA II yes, specify Cuben, Mexic 1 YES 2 NO Spec	en, Puerto Rican, atc.)	4. RACE — American Indian, Black, White, etc. Specific White				
LETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-17 1 1 1-17 1 1 1-17 1 1 1-17 1 1 1-17 1 1 1-17 1 1 1 1	or 5+) life. Do NOT use n	k done during most of working etired.)	16b. KIND OF BUSINESS/INDU	STRY				
BE COMPLET	Unk. Unk.  17. FATHER'S NAME (First, Middle, Last)  William Bohmer	Mailman	18. MOTHER'S N	Public Serv  AME (First, Middle, Meiden Surneme)  rine Smith	ice				
TO B	190. INFORMANT'S NAME (Type/Print) Margaret Bohmer			Route Number, City or Town, State, Zip C Baltimore, MD 2	1224				
	20e_METHOD OF DISPOSITION 1	20b. PLACE AND DATE OF I cemetery, cremetery or other Gardens of	Faith Cem.	6/21 Baltimore	Cnty., MD				
	Deman Del	wache).	2818 E. Balti	& Son Funeral H more St. Baltimo	re, MD 21224				
	23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):								
ALION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DAYS							
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):								
AL	PART II. Other significant conditions contribution of the C. Y	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
AN: ME	DID TOBACCO USE CONTR	BUTE TO CAUSE OF		10 X	1 TYES 2 X NO				
PHYSICIAN: MEDIC	EXAMINER?  1 YES 2 NO 1 Input let  27. MANNER OF DEATH 280. DA	TE OF INJURY 265 TIME O	26. PLACE OF DEATH (COTTHER:  Nursing Home 5 Residence OF 28c. INJURY AT		IDEO				
'n	1 Natural 5 Pending 2 Accident Investigation 3 Suinide 2 28e. PL	ACE OF INJURY — At home, farm, stre Idling, etc. (Specify)	WORK?  M 1 YES 2 NO	281. LOCATION (Street and Number of					
COMPLETED	4 Homicide determined  29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the I		at the time, date end place, end du	City or Town, State)	4.				
	2 MEDICAL EXAMINER: On the bed 29b. SIGNATURE AND TITLE OF CERTIFIER			e time, date end place, end due to the					
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	CAUSE OF DEATH (ITEM 27) (Type, Pr	1717	221	NE. 18, 1995				
	ATAOCCAH. P.  31. DATE FILED (MONTH), Day, Sharl S.  JUN 2 1 1995 Jan. 20	ISTRAR'S SIGNATURE	n.p. CHUNC	H HOSPITA	6,21231				
	JUN 2 1 1995 Jania	Market Andrew							



by the hospital or attending physician. be detached for use as the burial-transit /LAND 21215-0020

Pages 1, 2, 3 should

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 88700	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Deot, of Health and Mental Hydiene brion to burial cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAMSE OF DEATN (ITEM, 27) (Type, Print)

AV

REGISTRAR SO IGNATURE

DUNDALK

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH William Eugene Brunn, Jr 4.30 June 20. A 1995 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR 7. DATE OF BIRTH HOURS YRS 219 28 9944 62 Nov. Maryland 9a. FACILITY NAME (If not institution, give street and number 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 826 Creek Road Baltimore Essex 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore 1 YES 2 NO Essex FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 826 Creek Road 21221 U.S.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: 3 ₩idowed 4 Divorced BY Army 1953-55 White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11 Driver Taxi once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at William E. Brunn BE Frances C. Clark 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Frances C. Brunn Creek Road Baltimore, Maryland 21221 must be 20s. METHOD OF DISPOSITION
1 to Burlel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Buriel 2 Cremation 3 L 4 Donation 5 Other (Specify) Shepherd Ellicott City, MD. 6/23/95 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore Maryland 21221 23. FART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition\_ xes resulting in death) DUE TO (OR AS A CONSEQUENCE OF traumatic event. morn CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury Shu DUE TO other (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury. PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ont PERFORMED? shows any 1 TYES 2 NO 12 n 1 TES 3 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔯 UNCERTAIN 🗆 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 6 27, MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) marked. 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO ВУ 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Flural Route Number, City or Town, State) 60 COMPLETED 6 Could not be 4 Homicide 28 Hern 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of restigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29d. DATE SIGNED (Month), Day, Mar)

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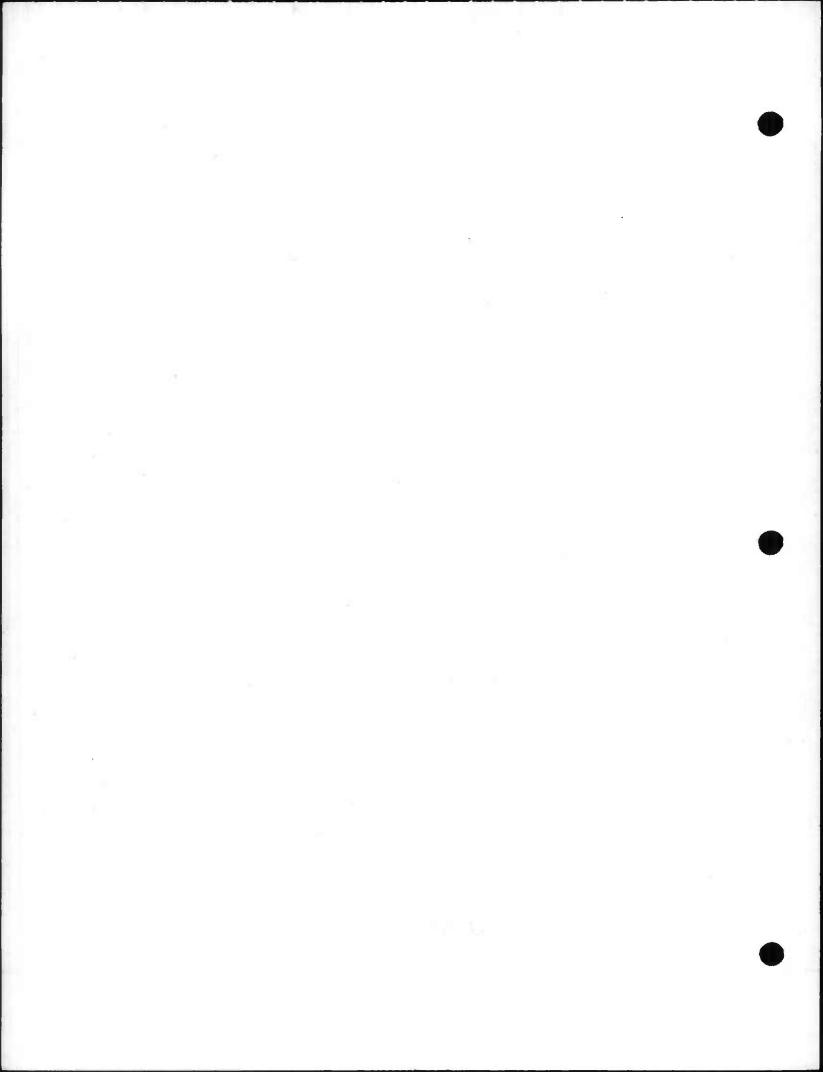
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29c. LICENSE NUMBER

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DIVISION	

		1 - STATE OF MARY REGISTRAR	LAND / DEPARTMENT OF H CERTIFICATE OF	EALTH AND MENT	TAL HYGIENE REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last)		2. 0/	TE OF DEATH	3. TIME OF DEATH						
		William E. Butcher		Jı	me 10, 1995	8:02 P. M						
P		218-44-8368 1X M 2 G F 4	7 YRS.   In under 1 YEAR   MONTHS   DAYS	HOURS MIN. 7. DA	TE OF BIRTH	Country ARYLAND						
. 2, 3 should	TOR	99. FACILITY NAME (If not institution, give street and number)  96. CITY, TOWN OR LOCATION OF DEATH  VA Medical Center  BALTIMORE  N/A										
if. Pages 1	DIRECTOR	MARYLAND 10b. COUNTY N/A	BALTIMORE			10d. INSIDE CITY LIMITS? 1 YES 2 NO						
an. ransit permit.	FUNERAL	1121 N. CAROLINE STREET		1213	10g. CITIZE	S .						
215-0020 attending physician. se as the burial-transit	BY FUI	11. MARITAL STATUS  1 Never Married  12. WAS DECEDENCE EVER IN U.S. ARMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxican, Puerto Rican, etc.)  14. R  15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxican, Puerto Rican, etc.)  16. R  17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxican, Puerto Rican, etc.)  18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuben, Maxican, Puerto Rican, etc.)										
21 al or for u	COMPLETED	15, DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondacy (0-12) College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) STEEL WORKER	of working	16b. KIND OF BUSINESS/INDUSTRY  BETHLEMN STEEL							
MARYLAND 2. retained by the hospital of S should be detached for notified at once.		17. FATHER'S NAME (First, Micolin, Last) WILLIAM VENABLE		16. MOTHER'S NAME (First AGNES BU	II. Middle, Meiden Surname)							
, MARY be retained b ge 5 should l e notified	TO BE	19a. INFORMANT'S NAME (Rype/Print) SHARON BUTCHER	19b. MAILING ADDRESS (Street at 617 LENNOX	STREET BA	umber, City or Town, State, Zip C LTIMORE, MA	ARYLAND21217						
MORE, ge 6 may be director, page		1 LABurial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	bb. PLACE AND DATE OF DISPOSITION (National Section Control of the Place) GAR	RISONFOR6	ate 20c Location — ch -23 Baltimo	ore, MARYLAND						
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		21. SIGNATURE OF FUNERAL SERVICE HERBEE		CARROLL	FUNERAL HOP	ME NORTHAVE.						
within 24 hours within 24 hours ppletely filed in b cremation, or referent, the media		23. PART I. Enter the diseases, or complications that cause shock, or heart feliure. List only one cause on IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Due to (or as	ed the deeth. Do not enter the modesch line.  A CONSEQUENCE OF):	de of dying, such as c	ardiac or respiratory arres	Approximate Interval Between Onset and Death						
P.O. BOX 68: sth certificate be execute tending physician and or all Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. Pneumonia oue to (or as a consequence of):  Advance Immunodeficiency Syndrome Due to (or as a consequence of):  d.										
w requires that the death been signed by the attent or of Health and Mental shows any injury, or	MEDICAL O	PART II. Other algorificant conditions contributing to deeth	but not resulting in the underlying	ceuse given in Part I.	24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO						
3 eb 8 es E	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE ( 25. WAS CASE REFERRED TO MEDICAL EXAMINER? V. HOSPITAL:	26. PLACE OF DEATH (Check only one)  OTHER:	UNCERTAIN								
PHYSICIAN: The this certificate hi with the State Cirked, or Item	IYS	1 ☐ YES 2 ☐ NO 1 ☐ IN Inpetient 2 ☐ ER/Out  27. MANNER OF DEATH 28s. DATE OF INJURY		S Residence 6 DO								
	B	1 🔁 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY WOR	RK? ES 2 NO	28d. DESCRIBE HOW INJURY OCCURED							
S affe 25	ETED	4 Homicide determined building, etc. (Sp.	acity)	, c	OCATION (Street and Number or fty or Town, State)							
경크이트	COMPLET	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my known one)  2 MEDICAL EXAMINER: On the basis of examinating										
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER	29d. DATE S	SIGNED (Month, Day, Year)						
5 5 3 W	10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, Print)	85531	0 6	110/95						
		Cynthia Soriano, M.D., 22 Sor	uth Greene Street	, Baltimore	, Maryland	21201						
		31. DATE FILED (MONTH, PORTE) Jalia dispetitore lan	ATHE									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit.

		FOR STATE REGISTRAR	STATE OF MARY					EALTH AND DEATH	MENTAL HYG			
		1. DECEDENT'S NAME (First, Middle, Lest) Thomas W.	Prachos						2. DATE OF DEAT MONTH	H DAY	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	DZ GDIICG.		Jr.	IF UNDER	1 YEAR	IF UNDER 24 HRS.	June 7. DATE OF BIRTS	4	995	EST 7:45P
		214 86 0749	1 💢 M 2 🗆 F	31	YRS.	MONTHS	DAYS	HOURS MIN.	Dec. 3,	1963	Count	ryland
α		9e. FACILITY NAME (If not institution, give s				9b. CITY,		R LOCATION OF D	EATH	9c, CO	UNTY OF I	
a O E	716 N. Charles St., #610 Baltimore N/A									/A		
DIREC	- 19	Maryland 106. COUNT	N/A		10c. CITY	, TOWN O	R LOCAT		altimore			10d. INSIDE CITY LIMITS? 1 YES 2 \( \text{NO} \) NO
FIINERAL		716 N. Charle	es St., #610				101	ZIP CODE	201			what country?
1		11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. &	RMED			ENDENT OF HISPAI	NIC ORIGIN? (Specifin, Puerto Rican, etc.	y Yea or No	14. RAC	E — American Indian,
2		1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR					2 X NO Specif		•)		"White
ETED		15. DECEDENT'S EDU (Specify only highest grade	completed)	1	ECEDENT'S I Give kind of w e. Do NOT use	ork done o	CUPATIO	N st of working	16b. KIND OI	BUSINESS/IN	NOUSTRY	
1 4		Elementary/Secondary (0-12)	College (1-4 or 5+)	5.00	Lamp I		orer		Ant	ique :	Shop	
at once.		17. FATHER'S NAME (First, Middle, Last) Thomas W. Br	ashears, Sr.						ME (First, Middle, Ma			
2 8	H	19e. INFORMANT'S NAME (Type/Print)	asilears, Sr.		Db. MAILING	ADDRESS	(Street a		P. Whee		in Codel	
		Robert C. Hooker							610, Bal			21201
must be		20a. METHOD OF DISPOSITION  1	ooval from State	metery, cr	AND DATEO	er place)	TION (Na	tory 6	DATE 204	Balt:		
niner		21. SIGNATUBE OF FUNERAL SERVICE LIC	CENSEE	2001	.i iioui	22.1	AME AN	D ADDRESS OF FA	CILITY			e, MD
medical examiner		CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore,MD2128										
medic		23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
2	disease or condition Toxical access and the second access access and the second access and the second access and the second access and the second access and the second access and the second access and the second access and the second access and the second access and the second access and the second access access and the second access access and the second access access and the second access access and the second access access and the second access access access and the second access access access and the second access access access access and the second access access access access access access and the second access access access access access access access access access access access access access access access access access access acces									7 MOS		
event,	Due to (or as a consequence of):  Retroviral Intation  1274									112 - 5		
ry, or other traumatic		if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):										ICAN
FICA FI		cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events	c. DUE TO (OR AS	A CONSE	OUENCE OF	h:						
or other		reaulting in death) LAST	d									
injury.		PART II. Other aignificant condition		but not	resulting in	the un	derlying	cause given in		S AN AUTOPSY	24b	. WERE AUTOPSY FINDINGS
M C		CMV Retin	itis, Wa	57)	ng S	yr	dr	ome		S 2 DATO	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
of S		DID TOBACCO USE CONTI	PIRLITE TO CALISE O	DE DE	ATH YES	. I	IO ID	UNCERTAIL				1 TYES 2 NO
ed, or item 23 PHYSICIAN		25. WAS CASE REFERRED TO MEDICAL EXAMINER?			CE OF DEATI	1 (Check o	nly one)	UNCERIAII	<u> </u>			
or item		1 TYES 2 THO  27. MANNER OF DEATH	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Out 28e. DATE OF INJURY	patient :	3 DOA	-	ing Home		6 Other (Specify)			
marked, BY PH	- 10	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		26b. TIME INJU		28c. INJU WOI 1 🔲 Y		28d. DEŞCRIBE H	O YRULNI WC	CCURED	
28 Is	+	3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At he	ome, farm, st	reet, facto	ry, office		281. LOCATION (St. City or Town, S		er or Rural i	Route Number,
item it			CIAN: To the best of my know									
COMPL			R: On the beels of examination	on and/or	Investigation	, In my op	rinlon, de			, and due to t	the cause(	a) and menner as stated.
IMPORTANT: II		296. SIGNATURE AND TITUE OF CERTIFIER	MD					D383	BER X	29d. DA	TE SIGNED	(Month, Day, Year) $U-95$
		30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DE	AAA			15-1	C- S+ C-		01 3	2	1287
	1	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S DA	V.()	h00	VVL	101	re still	rnegie 2	72, 54	ul 17 m	Orm, M.O
		JUN 2 1 1995 A		-								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

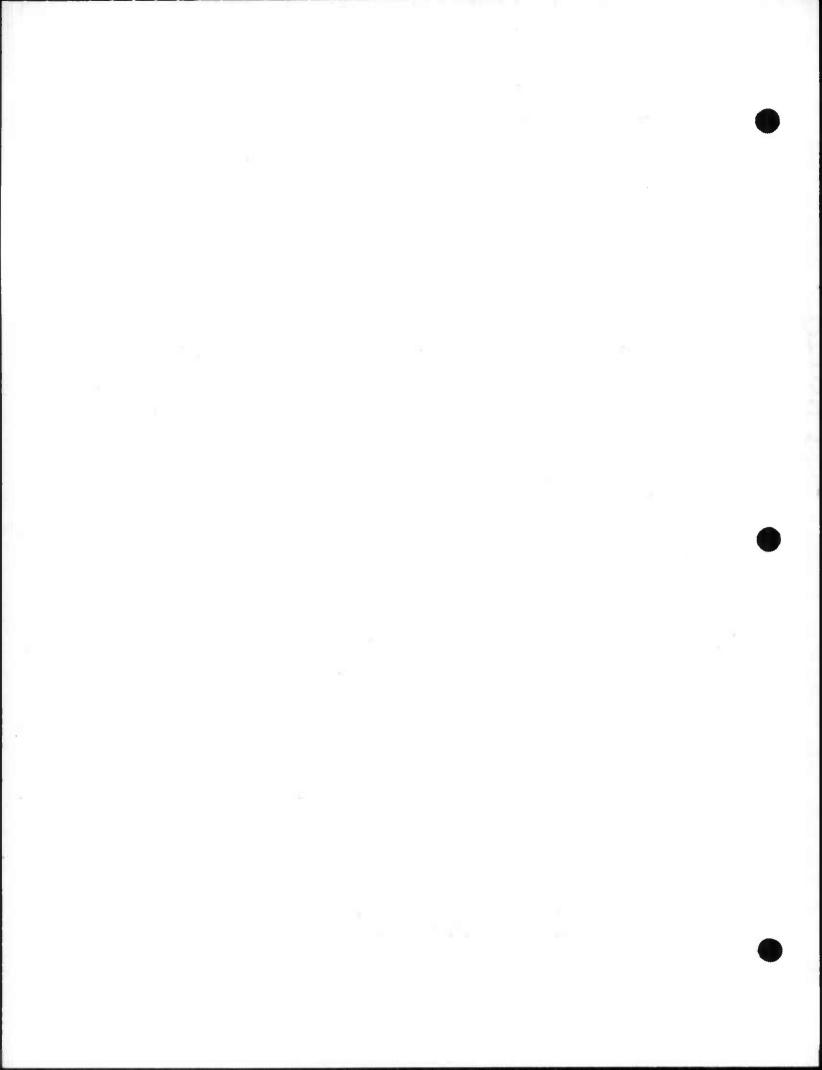
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATN  3. TIME OF DEATN												
	SAMUEL JAMES BOURKE JUNE 12, M 995 YEAR 8:42 p. M												
	4. SOCIAL SECURITY NUMB							IF UNDER 1 YEAR   IF UNDER 24 HRS. 7, DATE OF BIRTH					LACE (State or Foreign
	213-10-7839	9	1 X M 2 F 76 YRS.			MONTHS	DAYS				918	Country	yland
	9s. FACILITY NAME (If not in	2.414	9h CITY	TOWN /	OR LOCATE	ON OF DE			INTY OF DE				
Œ	Good Samari						ltim		ON OF DE	AIN .	N/		AIN
DIRECTOR	RESIDENCE OF DEC		ospecuc			500	CCUII	UILE			14/1		
H.	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY
ā	Maryland	N/A			Ba	ltim	ore						LIMITS?
AL	10e. STREET AND NUMBER						101. ZIP CODE 10g. CITIZEN OF WHAT					HAT COUNTRY?	
Ä	4005 Belwoo	od Avei	nue					2120	06		u	S.A.	
FUNERAL	11. MARITAL STATUS 1 Never Married 2	Manufact	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	CENDENT C	F NISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	a or No—	14. RACE	- American Indian, White, etc.
ВУ	3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DATES			1 YES	2 X NO	Specify			Specify	
	15. DEC	EDENT'S EDUC		orld War		USUAL O	COURATIO	041					White
	(Specify only Elementary/Secondary (0	highest grade	completed)	(G	ive kind of Do NOT u	work done se retired.)	during mo	ost of working	ng	16b, KIND OF BL	SINESS/INI	DUSTRY	
7	6th grade	-12)	College (1-4 or 5	+)	umbe	,				Plumt	ina I	Compa	nu
COMPLETED	17. FATHER'S NAME (First, MI	iddle, Lasi)						18. MOTI	MER'S MAI	ME (First, Middle, Maider		-	, to
	Jame	s 1	Bourke							erine Gay			
8	19a, INFORMANT'S NAME (7)	i/pe/Print)		19	b. MAILING	ADDRESS	3 (Street a			Number, City or Tox		n Code)	
2	Shirley L.	Benne	tt (Daugi							, Kingsvil			21087
	204 METHOD OF DISPOSITI	ON		20b.PLACE	AND DATE	OF DISPOS	ITION (Na	ame of		DATE 20c 10	CATION	City or Tow	n State
	1 🗷 Burial 2 🗆 Crematio 4 🗆 Donation 6 🗆 Other		oval from Stata	Garde	matory or o	ther place	ith	Cem.	E	6/16/95 Ba	ltimo	ore. I	Maruland
	21. SIGNATURE OF FUNDAL	L SERVICE LIC	ENSEE			22.	NAME AL	ND ADDRES	SS OF FAC	CILITY			
	D ///	- F	11	'						eral Home ane, Balti	maka	il.d	21213
	23. PART   Enter the di	seases, or c	omplications the	t caused the de	eth. Do i	not entar	the mo	de of dyl	ng auch	ane, butt	iratory ar	, Mu.	Approximate
	anock, or ne	eert tellure. I	rist only one cer	ise on each line	t.	_					matory at	,	Interval Batween
1	iMMEDIATE CAUSE (Fin disease or condition	)#II	Kers	PIRANO	ny	1	MIL	vv	تو_				Onset and Death
	resulting in death)		DUE-TO	(OR AS A CONSE	DUENCE O	F):							-
z	- COPIX												
CERTIFICATION	Sequentially list conditions, if any, laading to immediate  OUE TO (OR AS A CONSEDUENCE DF):												
2	Cause. Enter UNDERLYill CAUSE (Disease or injur		D										
#	that initiated eventa		DUE TO	(OR AS A CONSE	DUENCE O	F):							
100	resulting in death, EAS		d										
	PART ii. Other algnificat	nt condition	a contributing to	death but not r	esuiting	in the un	derlying	g ceuse g	lven in i	Part I. 24s. WAS AN		24b. V	WERE AUTOPSY FINDINGS
MEDICAL			pros	かって		3	524	1	-	PERFO	1		WAILABLE PRIOR TO COMPLETION OF CAUSE
			1							1 □ YES	MU		OF DEATH?
	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	SXI	NO F	1 UNC	ERTAIN				l les 2   No
Χ	25. WAS CASE REFERRED TO					TN (Check							
Sic	EXAMINER?  1 YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Ra	sidence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		26a. DATE OF (Month, D	INJURY	26b. TIM		28c. INJ	URY AT		28d. DESCRIBE HOW	INJURY OC	CURED	
BY		Pending nvestigation	(month, b	ay, rour)	,,,,,,	M	_	PRK?	] ND				- 1
	3 Suicide 6 0	Could not be	28a. PLACE C	F INJURY — At ho stc. (Specify)	me, farm, :	street, fact	ory, offici			26f. LOCATION (Street City or Town, State	and Number	or Rural Ro	ute Number,
ш	4 Nomicide	datarmined		oral (opcony)						City or lown, State	,		
7	29a. CERTIFIER 1 CERTI	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	sth occum	ed at the ti	me, data	and placa.	and dua	to the cause(a) and ma	nner as ste	lad.	
COMPLET										time, data and place, as			and manner as stated.
Ö	296. SIDNATURE AND THE				~				NSE NUM				Month, (fay, Year)
₾	UTTILL	au	1	) h	1 1	-				170	<b>D</b>	6/20	4/21
2	30. NAME AND ADDRESS DF											(	, , , ,
	Dr. Jose t	Hernan	dez, Per	ry Hall	Medi	cal	Cent	ter,	9660	Belair Ro	1., B	alto.	Md. 21236
	31. DATE FILEO (Month, Day, )	MILINI 9	1 TOOL	ALVA OF	dian	Carl-1	1						
	6/14/93	JUNA	ע פבבו וב	James and			•						

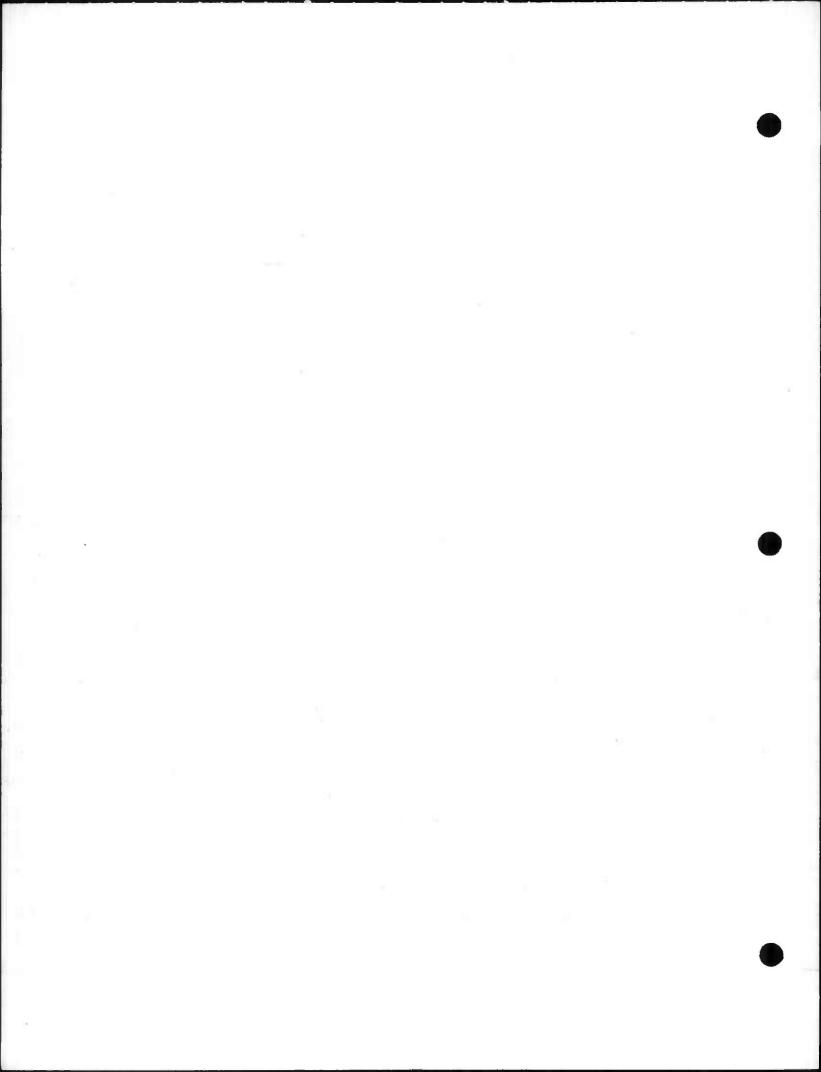


			1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	RTMENT O	F HEALTH	AND M		IENE NO.		
			1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEA	TN		3. TIME OF DEATH
			RACHEL	MAE			CAIN	E		JUNE 20	), 1995	YEAR	1:38A
P	_		4. SOCIAL SECURITY NUMBER 241-62-8530	5. SEX 6 1	. AGE (In yrs. les		IF UNDER 1 YE	AR IF UNDE	R 24 HRS.	7. DATE OF BIRTY (Month, Day, 16	7,1927	8. BIRTH	PLACE (State or Foreign Y) CAROLINA
	should		9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TO	WN OR LOCAT	ION OF DEA			INTY OF D	
	2,3	CTOR	THE JOHNS HOP	KINS HOSP	ITAL		ВА	LTIMOR	RE CIT	ſΥ	N/A	-N3	A
	pa"	ı iii l	RESIDENCE OF DECEDENT  10e, STATE 10b, COUNTY	,		100 CIT	Y. TOWN OR L				,,,		
	permit. Pages	DIR	N.CAROLINA	n/a		100. 011	2.5	ANOKE	RAPI	DS			10d. INSIDE CITY LIMITS? 1 YES 2 NO
		ERAL	117 LINCOLN						212	27870		IZEN OF V	STATES
	me bunal-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2)(X)	MED	If yo	DECENDENT	OF HISPANIC an, Maxican,	C ORIGIN? (Speci , Puarto Rican, et	fy Yes or No-	14. RACE	American Indian, c, White, etc.
7			15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY									DLACK	
DR)	1	ETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(G	Do NOT us	work done durin	g most of worki	ing	100, KIND U	P BUSINESS/IN	DUSTRY	
	))	4	6 TH	-		HOME	MAKER					ome	
	1		17. FATNER'S NAME (First, Middle, Last) ADOLPHUS JC	ONES				18. MOT		E (First, Middle, M PHINE	BAKER		
MAR	notified	TO B	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING				oute Number, City of			
		-		.EMING		911	16 J(	DUSTIN	G LAN	E,UPPER	MARLBO	ORO,N	IC 20772
IMORE Page 6 may	must b		20a. METHOD OF DISPOSITION 1 N Journel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	206. PLACE A	ND DATE OF	of disposition ther place! MEM(	N (Neme of OR I AL	CEM.	1	e. location — ROANOKE		
death.	at. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	Junou			22. NAM	E AND ADDRE	SS OF FACI	LITY			'H AVENUE
in 24 hours aft	cremation, or remo		23. PART t. Enter the diseases, or shock, or heart failura. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	emplications that class only one ceuse	eused the da on each line 25/5 R AS A CONSEC	DUENCE OF	not enter the	mode of dy	ring, auch	aa cardiac or i	reapfretory ar	reat,	Approximate interval Between Onset and Death 5 days
P.O. BOX 68 th certificate be execu	Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	AORTO DUE TO (OI	R AS A CONSEC	DUENCE OF	sine	017	ease	2			3 weeks
ADS At the d	pt. of Health and Mental 3 shows any Injury, o	MEDICAL (	PART II. Other aignificant conditions Pyoderna Ga	contributing to de	eth but not n	esuiting i	in the under	lying cause	given in Pa	PE	S AN AUTOPSY REFORMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
			DID TOBACCO USE CONTR	IBUTE TO CAUS	SE OF DEA	тн үе	S NO	M UNC	CERTAIN				
Y a t	- 60	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:						
	8 B	PHYS	27. MANNER OF OEATH	28a. DATE OF IN.		DOA 28b. TIM		Nome 5 Re		Other (Specify,		011050	
			1 Natural 5 Pending	(Month, Day,			URY	WORK?		zed. OEŞCHIBE N	OW INJUNY OC	COMED	
OR ATTENDING	after death with	ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	Chi. on Tourn Chatal								or Rural A	oute Number,
DIVI OR AT	hours a	Ē	29e. CERTIFIER	NAN. To the control									
HOSPITAL	= 3	COMPL	(Check only one)  2 MEDICAL EXAMINER	IAN: To the best of my									and manner as statud
HOS	TAN	- 10	29b. SIGNATURE AND TITLE OF CERTIFIE						ENSE NUMBI				
5 E	be filed within	O BE	S. Gold		J. Ph	. 0-			11473		≥ 6		(Month, Day, Year)
		C 1	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLES	OF DEATH STEE	1 0 T /T	0-1-4)						

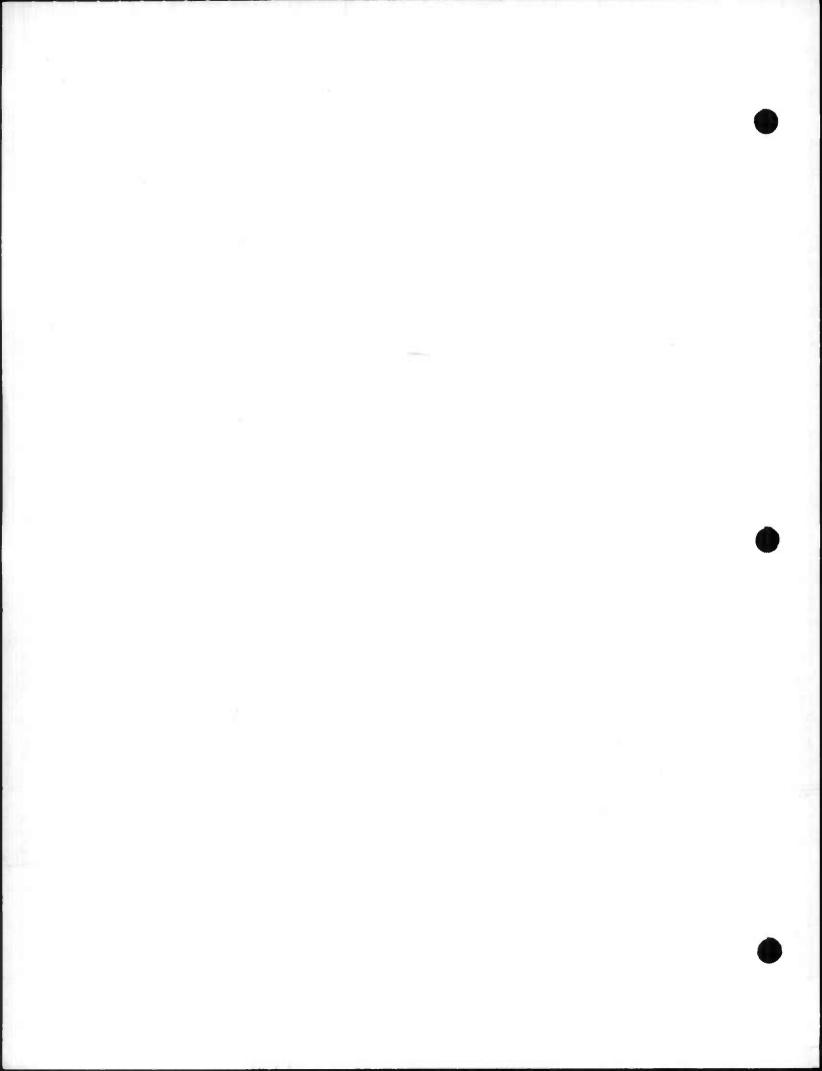
Johns Hopkins

SOF PERSON WHO COMPLETED GASE OF DELINITION OF DOWN.

DOWN THE SOFT THANKS SIGNATURE ROUGHLAND AND MUNICIPAL PROPERTY OF THE SIGNATURE ROUGHLAND A



		1 - FOR STATE OF REGISTRAR	MARYLAND / DEPARTMENT CERTIFICATE	OF HEALTH AND N	MENTAL HYGIEN	E						
		1. DECEDENT'S NAME (First, Middle, Last)	RBIN		2. DATE OF DEATH DA		3. TIME OF DEATH  5.50 P M					
0		4. SOCIAL SECURITY NUMBER 5. SEX $220-82-2689$ $1 \square$ M $_2$ $\bigcirc$ F	6. AGE (In yrs. lest birthday) IF UNDER MONTHS MONTHS	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 10.19	8. BIR Cou	THPLACE (State or Foreign intry)					
permit. Pages 1, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Co	enter By	ithmore		9c. COUNTY OF						
Lages 1,	DIRECTOR	100. STATE 10b. COUNTY	10c. CITY, TOWN OF				10d. INSIDE CITY LIMITS? 1 XYES 2 NO					
лят реппп	FUNERAL	3915 Liberty Heigh	hts Dre	101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?					
me bunal-tra	BY FUN	1 Never Merried 2 Merried FORCES?	1 L YES 2 KNO	AS DECENDENT OF HISPANI yes, specify Cuben, Mexicen YES 2 NO Specify:	C ORIGIN? (Specify Yes , Puerto Ricen, etc.)	Bio	CE — American Indian, ack, White, etc.					
w use as n	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5	16e. DECEDENT'S USUAL OC (Give kind of work done di life. Do NOT use retired.)		16b. KIND OF BUS	INESS/INDUSTRY	Black					
oetached ro	MPL	17. FATHER'S NAME (First, Middle, Last)	Whemp1		NA							
8 8	BE CO	Raymond Davis  100. INFORMANT'S NAME (TyposPrint)		Veral	e (First, Middle, Melden :	bin						
be notified	5	Veraline Corbin	3915 Liber		Ive. Balt	more. 1	Nd. 21215					
or must		20s METHOD OF DISPOSITION 1 P Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF DISPOSITE Commetery, crematory or other place)	PK	6-2295 Ran	dallstou	4					
or removal.  medical examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Mo	ame and address of factor the Funeral 300 Wabas	Home - W	est						
		23. PARTI. Enter the diseases, or complications the shock, oxpeart fallure. List only one call immediate CAUSE (Final	at caused the death. Do not enter t	he mode of dying, auch	as cardiac or reapir	atory arrest,	Approximata interval Between Onset and Death					
ul. cremation, event, the		disease or condition resulting in death)	O OR AS A CONSEQUENCE OF:									
to buria	TION	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
Mental Hygiene prior to buria liury, or other traumatic	CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa  C. Due TO (OR AS A CONSEQUENCE OF):										
and Mental Hy Injury, or	_	PART II. Other significant conditions contributing to	·	0 -	,							
and A	MEDICAL		o beauti but not reading in the unc	enying cause given in P	24a. WAS AN PERFORI	WED?	No. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
State Dept. of Health  Item 23 shows an		DID TOBACCO USE CONTRIBUTE TO CA			这		1 TES 2 NO					
he State C	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO HOSPITAL: 1 Ninpatient 2	26. PLACE OF DEATH (Check of OTHER:		Other (Specify)							
death with the	у РНУ	1 Netural 5 Pending	FINJURY 28b. TIME OF 10 INJURY M	8c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCUREO						
after 28 I	TED BY	3 Suicide 8 Could not by 28e. PLACE	OF INJURY — At home, farm, street, factor, stc. (Specify)		28f. LOCATION (Street ar City or Town, Stete)	nd Number or Rura	l Route Number,					
in 72 hours	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of MEDICAL EXAMINER: On the best of	of my knowledge, death occurred at the tin				(e) end manner se stated.					
be filed within 7	BE C	296. SIGNATURE AND TITLE OF CERTIFIER	0.0 10	29c. LICENSE NUMB	DER	29d. DATE SIGNE	ED (Month, Day, Year)					
P P	5	36. NAME AND ADDRESS OF PERSON WHO COMPLETED CALL  WWW PLANTY 2		15 Baltim			8195					
	- 1	31. DATE FILED (Month) Day Man 32. REGISTR	600 liberty Ho	THE TOO IT I W	DYC MV	21215						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If them 28 te marked or them 23 chows any injury or other fraumatic event the medical avainant must be marked at a marked or them.
retainer	5 shoul	notifia
5 may be	tor, page	net ha
h. Page (	eral dinec	niner m
ofter death	y the fun noval.	near lea
4 hours	illed in by	a made
within 2	crematio	vent th
executed	and con o burial,	maffe a
cate be	physician re prior 1	ar frau
ath certif	tending al Hygier	or oth
at the de	by the a	v Iniury
quires th	n signed f Health	DWR 20
ne law re	has been Dept. of	n 23 sh
ICIAN: Th	ertificate the State	or Ben
NG PHYS	her this cath with	marked
ATTENDI	CTOR: At	28 ls
TAL OR	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the . be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	If Item
E HOSPI	E FUNER	RTANT
H D	で で 記	IMPC

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	OF MARYLAN		TMENT OF			NTAL HYGIE					
1. DECEOENT'S NAME (First, Middle, Lest)  2. DATE OF D MONTH										3. TIME OF DEAT	TH .	
	Nellie			CADLE			June 19 1995			3:24	M ks	
	4. SOCIAL SECURITY NUMBER 5. SEX		s. lest birthday)	IF UNDER 1 YEAR			DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Fo	-	
	233-58-4518 1 D M 2	/ /	YRS.	MONTHS DAY	ноция	Ju	ine 20,	1917	Ker	tucky		
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number)  Franklin Square Hospital  Residence of Decement  9b. CTY, TOWN OR LOCATION OF DEATH  ROSSVIlle  Baltimore											
1 22	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	ATION				Т	10d. INSIDE CITY	,	
	Maryland Baltimore		ı	Middle	Rive	r				LIMITS?	NO	
₹ %	100. STREET AND NUMBER				01. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?		
FUNERAL	2124 Coralthorn Roa		-		21220	_			S.A.			
	11. MARITAL STATUS  1 Never Married 2 Married FORCE	ECEDENT EVER IN U.S	ARMED	If yes,	specify Cuban, I	HISPANIC O Mexican, Pu	RIGIN? (Specify Your of Rican, etc.)	e or No-	Black	- American India , White, atc.	м,	
B	3 ★ Widowed 4 □ Divorced	, GIVE WAR OR DATES		1 - Y	S 2 NO	Specify:			Specif	White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a		USUAL OCCUPA			16b, KIND OF BU	JSINESS/IND				
1 =	Elementary/Secondary (0-12) College (	1-4 or 5+)	Ille. Do NOT us	e retired.)	nost or wonling							
M M	8	F	lousev	rife				Home	3			
	17. FATHER'S NAME (First, Middle, Last)  Chester Warren						First, Middle, Maide	,				
BE	19a. INFORMANT'S NAME (Type/Print)		401- 11411 1140				Gambe					
2	Edna Meyers						Number, City or Total			21220		
3	20a. METHOD OF DISPOSITION	20h PLA						_				
	200. METHOD OF DISPOSITION  1											
<u> </u>	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	1		22. NAME	AND ADDRESS	OF FACILITY	Υ \					
	Mount Deep	Efreki					Funeral ve.Bal				221	
	23. PART I. Enter the diseases, or complication	one that caused the	death. Do n	ot antar tha r	oda of dying	, auch aa	cardiac or read	oiratory arr	est.	Approxima	-	
	anock, or haart tailure. List only one cause on each line.  IMMEDIATE CAUSE (Final											
	disease or condition Coronary artery disease									10 ye		
		DUE TO (OR AS A COM										
N N	Hypertensive vascular disease									20 ye	ars	
ĄŢ	If any, leading to immediate cause. Enter UNDERLYING											
은	CAUSE (Disease or Injury C.	DUE TO (OR AS A CON	SEQUENCE OF	):						_		
CERTIFICATION	resulting in death) LAST											
	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE											
1 35		ting to death but h	or resulting i	in the undarry	ig cause give	an in Part	I. 24a. WAS AP PERFO		246.	WERE AUTOPSY FIF AMAILABLE PRIOR I COMPLETION OF C	то	
MEDIC							1 TYES	2 X NO		OF OEATH?		
2	DID TOBACCO USE CONTRIBUTE T	O CAUSE OF D	FΔTH YE	s $\square$ NO	7 UNCER	RTAIN [	*			1 YES 2 N	10	
IAN	25. WAS CASE REFERRED TO MEDICAL	26. P		H (Check only on		7	e 1					
SIC	HOSPII	AL: ent 2 ER/Outpatien	t 3 🗆 DOA	OTHER: 4 - Nursing He	me 5 🗆 Resid	lence 6 🗆	Other (Specify)					
BY PHYSICIAN:	27. MANNER OF DEATH  1 Neturel 5 Pending 2 Accident Investigation	Month, Day, Year)	26b. TIME INJI	JRY \	JURY AT ORK? YES 2 N		. DESCRIBE HOW	INJURY OCC	URED			
<u>a</u>	3 Suicide a Could not be 4 Homicide datarmined	PLACE OF INJURY — As building, atc. (Specify)	t home, farm, s	treet, factory, of	Ca	281.	LOCATION (Street City or Town, State	and Number	or Rural R	oute Number,		
COMPLET	29a. CERTIFIER (Check only one)  1 A CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Musi	MI	<u></u>	29c. LICENS	E NUMBER		29d. DATE	SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLET	ED CAUSE OF GEATH (	TEM 27) (Type,	Print)	D 46					9, 1995		
	Dr. Ayman Youssri M.D.	9000 Fran	nklin S	quare 1	rive B	Baltin	more Md.	2123	7-39	98		
	JUN 2 1 1995 July 201	COLSTRAR'S CONATUR	3									

**DIVISION OF** TO THE FUNERAL OR ATTENDIN TO THE FUNERAL DIRECTOR: At be filed within 72 hours after des IMPORTANT: If Item 28 is in

ON OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	
DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	
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e marked or Hem 23 shows any Injury or Mar Painnath second the madical according to another an action of the material	

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF H	EALTH DEAT	AND M	ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	0 11					2. DATE OF DEATN			3. TIME OF DEATH	1
	Dolores 1	n. Cratty					6 17 95			2:45	Ом
		5. SEX 6. AGE (In	y lest birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH			IPLACE (State or For	eign
	192-05-5766	MONTHS DAYS	HOURS	MIN.	Sept. II,	sylvania					
	9e. FACILITY NAME (If not institution, give street	96. CITY, TOWN C	R LOCATIO	N OF DEAT	TN	9c. COU	NTY OF D	EATN			
Ö.	Long View Nursing	3 Home		Man	chest	er		Can	rrol	1 County	
EC	10e. STATE 10b. COUNTY		10c, CITY	, TOWN OR LOCAT	ION					10d, INSIDE CITY	
DIRECTOR	Maryland Carr	roll County		Sykes	vi110	,				LIMITS?	
AL	10e. STREET AND NUMBER				ZIP CODE			10g. CITI	IZEN OF Y	WHAT COUNTRY?	-
FUNERAL	4209 Jefferson Av	/enue			2	1784		U.S	S.A.		
5		12. WAS DECEDENT EVER IN L FORCES? 1 YES	J.S. ARMED	13. WAS DEC	ENDENT OF	FNISPANIC	ORIGIN? (Specify Yes	or No-	14. RACI	— American Indian	١,
ВУ	1 Never Married 2 Merried  3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE				Specify:	Puerto Ricen, etc.)	- 1	Speci	White, etc. White	
	15. DECEDENT'S EDUCA	TION I	16a. DECEDENT'S USUAL OCCUPATION				I an amin on our			white	
ETE	(Specify only highest grade co	College (1-4 or 5 +)		ork done during mo		7	16b. KIND OF BUS	SINESS/IND	USTRY		
PL	Entrottes y concornas y (0°12)	2	L	PN			Hea1	th Ca	are		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTN	ER'S NAME	(First, Middle, Meiden	Surname)			
BE (	Bryan Downey					Ros	e O'Conno	r			
0	19e. INFORMANT'S NAME (Type/Print)						ite Number, City or Town				
	Mrs. Mary Barna		4209	Jeffer	son A	venu	e Sykesvi	11e,	MD :	21784	
	20a. METNOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removi	al from State 20b. P	LACE AND DATE O	F DISPOSITION (Na	me of		DATE . 20c. LO	CATION	City or To	wn, State	
- 1	4 Donation 6 Other (Specify)	l Qu	leen of	Heaven (			Done Pi	ttsbu	ırgh	, PA	
	. Buin a	[N. 14		HAIGH	T FU	NERA!	L HOME (P	.0. I	Box :	195)	- 1
_	- Wuan 9	1 - Hought		Sykes	svill	e, M	D 21784 (	410)-	-795-	-1400	
	23. PART I. Enter the diseasea, or con shock, or heert feilure. Lie	mplicetions that/csused to st only one ceuse on esc	he death. Do n h line.	ot enter the mo	de of dyin	ng, such i	as cardiec or reapi	ratory arr	eat,	Approximat	
	iMMEDIATE CAUSE (Final disease or condition	0.		`	( 1	٢.	1			Opset and	
	IMMEDIATE CAUSE (Final disease or condition resulting in desth)  Due to (or as a consequence of):  Due to (or as a consequence of):										
_	OUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
CA	Cause. Enter UNDERLYING CAUSE (Disesse Dr injury										
	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	):							
H	d.										
AL 0	PART II. Other significant conditions	contributing to death but	not resulting in	the underlying	ceuse gi	ven in Pa			24b.	WERE AUTOPSY FINE	DINGS
2	arterior	eratic te	unt 10	ularo			PERFOR			AVAILABLE PRIOR TO	
ME	Parhim	ons Per	eere				1 163 2	- Control		OF DEATH?	,
ž	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	S   NO	UNCE	RTAIN					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. HOSPITAL:	PLACE OF DEAT								
YSi	1 YES 2 NO	☐ Inpetient 2 ☐ ER/Outpeti	ent 3 🗆 DOA	OTHER: 4 Nursing Nome	5 🗆 Res	idence 6 (	Other (Specify)				
F	27. MANNER OF DEATN  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		IRY AT	2	8d. DESCRIBE NOW IN	JURY OCC	URED		
B₹	2 Accident Investigation				ES 2 🗌	NO					
ED	3 Suicide 6 Could not be determined	reet, fectory, office		24	Bf. LOCATION (Street e. City or Town, Stete)	nd Number	or Rural R	loute Number,			
COMPLETED	29e. CERTIFIER										_
MP	(Check only 1 CERTIFYING PHYSICIA	AN: To the best of my knowled									
8		On the basis of examination a	induor investigation	, in my opinion, or							ted.
H	296. SIGNATURE AND TITLE OF CERTIFIER	WD				238		29d. DATE	SIGNED	(Month) Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEAT	H HTEM 27) (Type,	Paint) 1				(	011	1145	
	WHFOATLA	COMPLETED CAUSE OF DEATH	y ain	54 /	d an	ch	ester	11 ~	10	1102	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI	URE	- '			1	/VI (		.,,	-
	JUN 2 I <sub>1995</sub>	Ali Handes	Rarball								

.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / D	EPARTMENT OF H	IEALTH AND ME	ENTAL HYGIEN	E						
	1. DECEDENT'S NAME (First, Middle, Last)	- 1 .		T	DATE OF DEATH	rdh.	3. TIME OF DEATH					
	Clarence	Crawford	5/		JUNE	14 19	35 3- PM					
		5. SEX 6. AGE (In yrs. last bi	VRS. MONTHS DAYS	IF UNDER 24 HRS. 7. HOURS MIN.	(Month, Day, Year)	BIRTHPLACE (State or Foreign Country)						
	9a. FACILITY NAME (If not institution, give stre	/ 01		OR LOCATION OF DEAT	<u>5-15-19</u>		faryland Y OF DEATH					
DIRECTOR	Levindale Hebr		Balti				imore City					
REC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?					
		imore	Dunda1k				1 TES 2 X NO					
FUNERAL	1503 Rita Rd		101	ZIP CODE			N OF WHAT COUNTRY?					
INE		12. WAS DECEDENT EVER IN U.S. ARME	70 100 100 000	21222		USA						
	1 Never Married 2 Married	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yea, sp	ENDENT OF HISPANIC ecify Cuban, Maxican, F 2 X NO Specify:	OHIGIN7 (Specify Yea Puerto Rican, atc.)	or No —	Black, White, atc.					
ВУ	3 X Widowed 4 Divorced			Z (ANO Specify.			Specify: White					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompfeted) (Give	DENT'S USUAL OCCUPATION kind of work done during me	ON at of working	16b. KINO OF BUS	INESS/INDUS	TRY					
ZE.	Elementery/Secondary (0-12)	College (1-4 or 5 +)	not use retired.)		Beth -	Sto	.1					
MO	17. FATHER'S NAME (First, Middle, Lest)	Naı	Illiakei	18 MOTHER'S NAME	(First, Middle, Meiden		5.1					
	George D. Craw	ford		Anna Be		Sumame)						
) BE	19e. INFORMANT'S NAME (Type/Print)		MAILINO ADDRESS (Street o			n, State, Zip Co	ode)					
욘	Clarence B. Cr		503 Rita									
	20a, METHOD OF DISPOSITION		DATE OF DISPOSITION (No	me of	DATE 20c. LO	CATION — CIT	y or Town, State					
	4 Donation 5 Other (Specify)	1 M Buriel 2 Cremation 3 Removal Irom State 4 Donation 5 Other (Specify)  Oak Lawn Cemetery 6-22 Baltimore, Md										
	21. SIGNATURE OF FUNERAL SERVICE LICEN	CS+ Conne	M Conr	nelly Fun Sollers	neral Ho		f Dundalk					
	23. PART I. Enter the diaeasas, or col	mplications that caused the death	h. Do no enter the mo	da of dying, auch a	s cardiac or reapi	ratory arres	t, Approximate					
	IMMEDIATE CAUSE (Final	st bnly bne ceuse bn each line.			- 1		Interval Between Onset and Death					
	disease or condition - e. Probable myreschel in far chin H8hr											
	disease or condition - resulting in death)  e. Probable myreseliel in farchin H8hm.  Due to (or as a consequence of):  Cardiac arrhyllimia = 1 year											
ON	DIE TO (OD AS A CONSEQUENCE OF											
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	200 10 (011 N3 N 00113E008	ence or).	7								
IFIC	CAUSE (Disease Dr injury that initiated eventa	DUE TO (OR AS A CONSEQUE	ENCE OF):									
ERT	resulting in death) LAST											
	PART II. Other significent conditions	contributing to death but not real	ulting in the underlying	Ceuse given in Pa	rt i. 24a. WAS AN	AUTOPSV	24b. WERE AUTOPSY FINDINGS					
CAL	Renal in	Milliana	4	y vodes grown in re-	PERFOR	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE					
9			1		1 NES 2	XNO	OF DEATH?					
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEATH	I YES □ NO □	UNCERTAIN	<u>- 1</u>		1 TYES 2 NO					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	26. PLACE C	OF DEATH (Check only one)									
YSIG	1 VES 2 NO	OSPITAL: Unperlant 2 ER/Outpetient 3 I	DOA 4 Nursing Hom	e 5 🗆 Rasidenca S 🗆	Other (Specify)							
F	27. MANNER OF DEATH  Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	86. TIME OF 28c. INJ	URY AT 26 RK?	d. DESCRIBE HOW II	JURY OCCUP	RED					
BY	Accident Investigation			ES 2 NO								
COMPLETED	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At home, building, atc. (Specify)	, farm, street, lactory, offic	26	Bf. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,					
7	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledge, death	occurred at the time, date	and place, and due to i	the cause(s) and men	ner as stated						
MO		On the beels of examination and/or inve										
ш II	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBE	R	29d. DATE S	IONED (Month, Ray, Year)					
Φ.	Mejani	M.D.		D448	217	> Au	me 19/4/99/					
5	SUNIL P. RATA		7) (Type, Print) S Reliee)	line Ou	ie R	n11.	in a series					
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	Food	wice we	1)8	3-000	more in					
	JUN 2 1 1995 Julia	Devoler Radell					Ì					

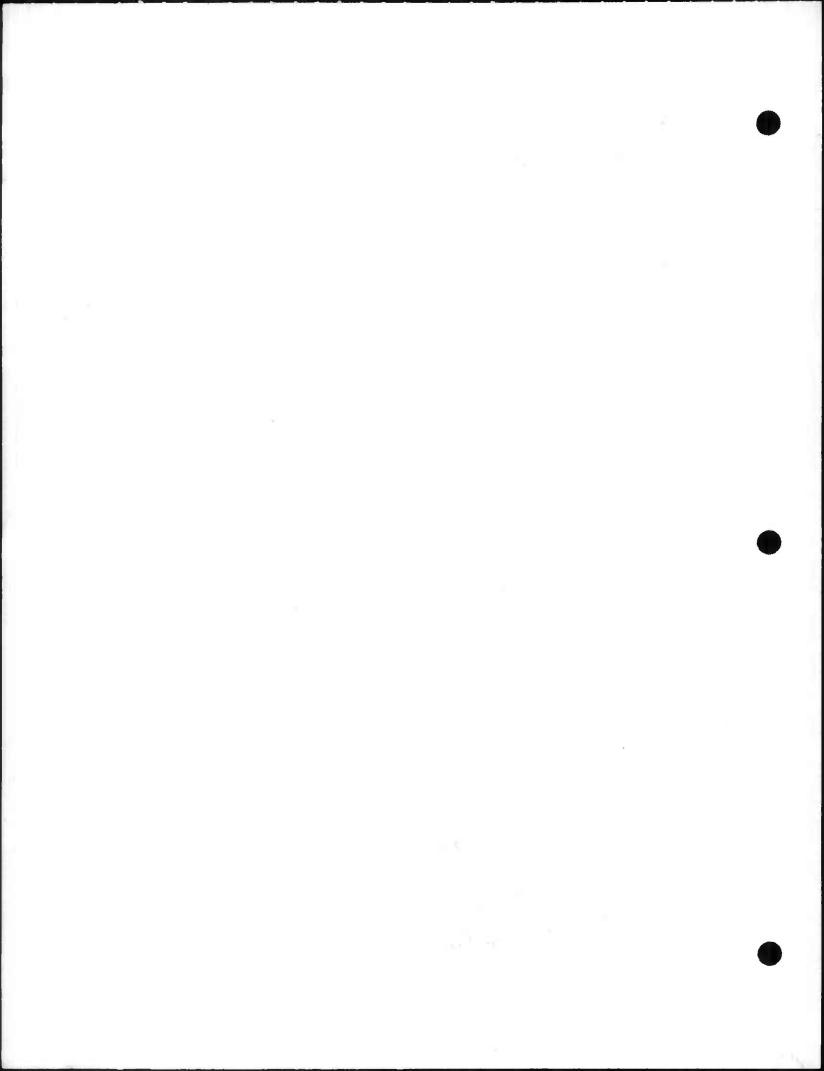
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)				10/11		DEA		2. DAT	E OF DEATH			3. TIME OF DEATH
	Dorothea		Н.	DOROFF						June 16, 1		L995		
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In	yrs. lest birthday		R 1 YEAR	IF UNDER	1 24 HRS.	7. DATE	E OF BIRTH	0, 1		9:52 a M  IPLACE (State or Foreign
	216-01-010	4	1 🗆 M 2 💢 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	.Lan	oth, Day, Year)	914	Count	ryland
	So. FACILITY NAME (If not in			Jan. 20, 1914					NTY OF D	,				
E C	Franklin Square Hospital						В	alti	nore			Dol.	-imor	e County
5	RESIDENCE OF DEC	EDENT										Dar	LIIIOI	e County
DIRECTOR	Maryland	10b. COUNTY	, Baltimore		10c, C	TY, TOWN								10d, INSIDE CITY LIMITS?
	10s. STREET AND NUMBER		balt imore	-		В	alti							1 TES 2 XXNO
FUNERAL							101	. ZIP COD				10g. CIT	IZEN OF V	WHAT COUNTRY?
N N	1224 N. 64t	h Stre	12. WAS DECEDEN						ltim				212	
	1 Never Married 2	Merried	FORCES? 1	YES	2 X NO	1	If yes, sp	ecify Cube	m, Mexice	n, Puerto	N? (Specify Yes Ricen, etc.)	or No-	14. RACI Black	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divo		IF YES, GIVE V	MAR OR DATI	ES							Speci	White	
8	15. DECI	EDENT'S EDUC	CATION	1	6a. DECEDENT	S USUAL O	CCUPATIO	ON		16	b. KIND OF BUS	SINESS/INI	DUSTRY	WILLE
ᇤ	Elementary/Secondary (0	highest grade	College (1-4 or 5	+)	(Give kind a life. Do NOT	work done use retired.)	during mo	st of working	rg					
필	N/A		N/A		Recei	ving	/Casl	hier			Se	ars		10-1
COMPLETED	17. FATHER'S NAME (First, Mi	ddle, Lest)						18. MOT	HER'S NA	ME (First,	Middle, Meiden	Sumame)		
BE (	Mike McNea							Ka	the	rine	Siewe	rts		
10 E	19e. INFORMANT'S NAME (7)				19b. MAILIN	G ADORES	S (Street a	nd Number	or Rural F	Route Nun	nber, City or Town	n, State, Zij	Code)	
-	Mary R. Dor		Sister)		1224	N. 6	64th	St.	, Bal	ltim	ore, M	ary1a	and 2	21237
	20e. METHOD OF DISPOSITI	n 3 🗆 Remo	oval from State	cemete	LACE AND DATE	other plecal	1			1	TE 20c, LO			
	1 Burial 2 & Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) Green Mount Crematory 6/19/95 Baltimore, Maryland  3 MAME AND ADDRESS OF FACTURE.													
	21. SIGNATURE OF PUNGSAL	SERVICE LIC	ENSEE // 1					D ADDRE			1 Home			
	1	1	1.11									imore	Me	1. 21213
	23. PART Enter the di	seasea, or c	omplications the	t caused ti	he death. Do	not enter	tha mo	de of dy	ing, such	h ss car	diec or respi	ratory an	rest,	Approximate
	IMMEDIATE CAUSE (Fin		Liet only one ceu	ise on eac	h line.									Interval Batween Onset and Death
	disease or condition													
	resulting in death)  s. Congestive Heart Failure  Due to (or as a consequence of):  6 days													
Z	Sequentially list conditions, 6 days													
Ĕ	if any, leading to immed cause. Enter UNDERLY	lleta	OUE TO	OUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	CAUSE (Disease or injur		OUE TO	OR AS A CO	ONSEQUENCE (	NE).								
	that initiated events resulting in death) LAST		302 10	(On AS A C	ONSEDUENCE (	<i>i</i> -j.								
CEI		-	l											
MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuee given in Part i. 24a. WAS AN AUTOPSY FINDINGS AMILABLE PRIOR TO													
음	_Chronic_Re	enal F	ailure								1 TYES 2			COMPLETION OF CAUSE OF DEATH?
M	Hypertens	Lon/Ch	ronic An	emia										1 YES 2 NO
ä	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF	DEATH Y	ES 😡 🛭	NO 🗆	UNC	ERTAIN	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF DE	OTHE								
YSI	1 TYES 2 X NO		1 X Inpatient 2		ent 3 🗆 DOA			e 5 🗆 Re	eldence	8 🗆 Othe	er (Specify)			
	27. MANNER OF OEATH  1 ☑ Netural 5 ☐ F	Pending	28e. DATE OF (Month, D.		28b. Til	JURY		RK?		28d. OE	SCRIBE HOW II	JURY OC	CURED	
BY	2 Accident	rvestigation				М		ES 2	] NO					
8		Could not be	25e. PLACE O building,	etc. (Specify)	At home, term,	street, tect	tory, affice				or Town, State)	nd Number	or Rural R	loute Number,
COMPLETED	29e. CERTIFIER													
MP	(Check only	FYING PHYSIC	CIAN: To the best of	my knowled	ge, death occur	red at the t	lme, dete	end place,	end due	to the ca	use(e) end men	ner as stat	led.	
8				xamination e	nd/or Investigati	on, in my c	opinion, de	eth occur	ed at the i	ilme, dete	and place, en	d due to th	e cause(e	and manner ee stated,
BE	290. SIGHATTIED AND TUTLE	OF CENTIFIER						29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
5	MAN		m					P	0824	3		Ju	ne 1	6, 1995
	30. NAMY AND ADDRESS OF													
- 1		7	M D OO	OO 12-4.	a m 1 - 1 - 1 - 1	Cann	re D	rive	. R	21+1	lmore,	MD	212	27
	Theran Adam	nson, I	M.D. 901	OU Fra	ankiin	Squa	IC D	TIVC	, ,	alti	inore,	עניז	212	37
İ	Theran Adam 31. DATE FILEO (Month, Day, Y JUN 2 1 199	son, r	32 REGISTRA	R'S SIGNATE	URE	Squa	IC D	1110	, д	alti	inore,	עניז		37



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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMEN CERTIFICAT	T OF HEALTH AND	MENTAL HYGI						
		1. DECEDENT'S NAME (First, Middle, Last) ROSC D(A	SICOLA			2. DATE OF DEAT	H DAY	YEAR 8:30 P				
P		4. SOCIAL SECURITY NUMBER 2/3-78-5/34	5. SEX 6. AGE (	86 YRS. MONTHS	ER 1 YEAR IF UNDER 24 HRS.  DAYS HOURS MIN.		(r)	B. BIRTHPLACE (State or Foreign Country)  Italy				
1, 2, 3 should	TOR	Se. FACILITY NAME (III not pratitution give street and number Conter Sec. COUNTY OF DEATH  GILL BOLAIR ROAD, DALTIMORC 21236 BALTIMORS  NIA  RESIDENCE OF DECEMENT										
permit. Pages	VERAL DIRECTOR	MARYLAND 106. COUNTY	NIA	BALT	DR LOCATION TMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
in. ransit per		616 BELAIR R			101. ZIP CODE Z / 2 3	36	UN A	en of what country?				
5-0020 nding physician. Is the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR DR D	WAS DECENDENT OF HISP If yes, specify Cuban, Maxi 1 YES 2 NO Spec	can, Puerto Rican, etc.	Yes or No— 1	4. RACE — American Indian, Black, White, etc. Specify:					
or atte	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 +)	life. Do NOT use retired.	during most of working )	18717.500	BUSINESS/INDU					
ND hospita ached	COMPL	17. FATHER'S NAME (First, Middle, Last)		homem		AME (First, Middle, Me	who.	me				
# 8 E	BE C	ANTONIO D.	NicoLo		Luci	A DIN	1202					
E, MAR  be retained  age 5 should  be netfilled	10	MARIE CAYE	er		SS (Street and Number or Rura			Cy MARYLAN				
Pe 6 may rector, pa		20a, METHOD OF DISPOSITION  1 M Buriel 2 C Cremation 3 C Ramo 4 C Donation 5 C Other (Specify)	evel from State	PLACE AND DATE OF DISPO	RAL Cometo		ALTIMA	ROLMARYLAN				
ALTIN desth. Pag funeral di sxamiliser		21. SIGHATURE OF FUNERAL SERVICE LIC	ENSEE		MBROSE FO	NCEAL HE	MCOF	LANS DOWNC				
DA d in by the or removal.		23. PART I. Enter the diseases, or c	omplications that caused	f the deeth. Do not ente	719 Hamm	MONOS A	espiratory arres	ROAD 2/227				
y filled in tion, or the me	-	IMMEDIATE CAUSE (Final disease or condition	ACUTE		ARDIAL	- 11:11	100	Interval Between Onset and Death				
ted within complete al, crem,		resulting in death)	DUE TO (DR AS A	CONSEQUENCE OF):	11 -17/-	11077	,,,	70.0				
UA 08 to be execut dician and or rior to buri	FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (DR AS A	CONSEQUENCE OF):								
th certificate ending physical Hygiene p	ERTI	CAUSE (Disease or injury that initiated events resulting in death) LAST  C. DUE TO (OR AS A CONSEQUENCE OF):										
that the death led by the attended by the attended lith and Mental H any injury, or	AL C	PART II. Other significant conditions	s contributing to death b	ut not resulting in the u	nderlying cause given in	n Part I. 24a. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO				
Sign Sign S	MEDIC	FAICE	IRE	GCB/ / V	O TICKIE	1 🗆 YE	S 2 ND	OF DEATH?				
has b Dept.	IAN:	DID TOBACCO USE CONTR		F DEATH YES		IN 🗆						
- F 2 2 5	PHYSICIAN:	EXAMINERY 1 YES 2 NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp	OKHE		6 (C Other (Specify)						
NG PHYSIC fler this co sath with	ВУ РН	27. MANNER OF DEATH  1. Natural 5   Pending 2   Accident Investigation	(Month, Day, Year)	28b. TIME OF INJURY M	THE SHAURY AT WORK?  1 YES 2 NO	26d. DESCRIBE HO	W INJURY OCCU	NED				
TTENDI TOR: A after de	TED	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, stc. (Toeco	— At home, farm, street, fac r/y)	tory, office	28f. LOCATION (Sower and Number or Rural Route Number, City or Town, State)						
TAL OR TAL OR 72 hour	COMPLE	25%. CERTIFIER COMMON CONTROL PHYSIC COMMON 22 MEDICAL EXAMINES	DAN: To the best of my knows	edge, death occurred at the and/or investigation, in my	firms, date and place, and du opinion, death occursed at th	e to the cause(s) and e time, date and place	manner as stated , and due to the o	: :euse(s) and manner as stated.				
TO THE HOSPI TO THE FUNEF De filed within	BE	290. SIGNATURE AND TITLE OF SERTIFIER	Cha		29t. LICENSE MI			16/95				
<u></u>	5	30. NAME AND AUTHERS OF PERSON WHO LOUIS RIVERS 5	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Print)	Baltima	RC MAR	VLAN	0 2/236				
		JUN 2 1 1995 Jul	JA REGISTRAR RIGH	fruge		7						

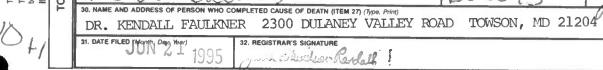
No contract of 

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the normal reads from the retained by the hospital or attending physician.

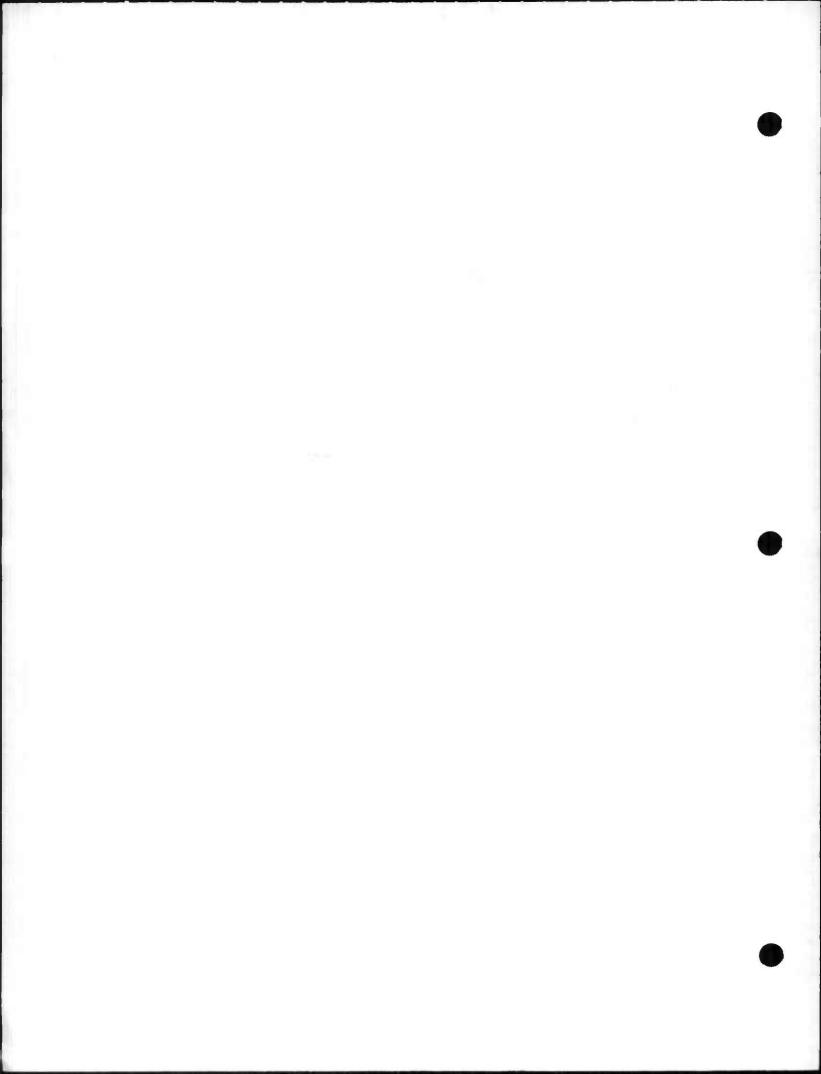
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item12,20,Film724,6	5/21/95,	lt						7	)	0/0/		
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR	TMENT OF	HEALTH AND	MENT						
	1. DECEDENT'S NAME (First, Middle, Last)				IOAIL O	DEATH	2 04	REG. NO			A 71115 OF BEATH		
	GUADIEC CEAN ED	POPOTOW					MO	NTH D	AY	YEAR	3. TIME OF DEATH		
	CHARLES SEAN FR							T Table	5	995	3 = 10.		
	220-07-3678	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER 1 YEAR MONTHS DAYS		7, DA	TE OF BIRTN onth, Day, Year)		8. BIRTN Countr	IPLACE (State or Foreign		
	220-07-3676	1 X M 2 - F	77	7 YRS.		noons and	Ju	1. 5, 1	917	land			
	9e. FACILITY NAME (If not institution, give str		9b. CITY, TOWN	OR LOCATION OF	DEATH		9c, COL	INTY OF D	EATN				
DIRECTOR	Stellar Maris Hosp	Towso	Towson					Baltimore					
M	10e, STATE 10b, COUNTY	10c. CIT	10c. CITY, TOWN OR LOCATION					10d, INS					
뜽	MD N/	l Ra	ltimore				LIMITS?						
	DOTTETHOLE TO NOT THE												
A I	107. ZIP CODE 10g. CITIZEN OF WHAT										YHAT COUNTRY?		
핒	2517 E. Northern I	Parkway				21214			U.	S.A.			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPA			ANIC ORI	GIN? (Specify Yes	or No-	14. RACE	— American Indian, x, White, etc.		
	1 Never Married 2 🖔 Merried	IF YES, GIVE Y	YES 2	NO		specify Cuben, Mexics 2 17 NO Specification		to Rican, etc.)		7.7			
B	3 Widowed 4 Divorced	3/41-1	3/41-12/45				Cffy: Spec			Black			
	15. DECEDENT'S EDUC	ATION	16e. Di	DECEDENT'S USUAL OCCUPATION				6b. KIND OF BU	DUSTRY				
COMPLETED	(Specify only highest grade of		(0	ive kind of a	vork done durina r	nost of working	- 1						
اۃ	Elementary/Secondary (0-12)	College (1-4 or 5 a	201lege (1-4 or 5+)			Bug							
Σ		r yr.		Contractor				Bus Co					
81	17. FATNER'S NAME (First, Middle, Lest)					18. MOTHER'S N	AME (Firs	t, Middle, Maiden	Sumame)				
w	Rubin Frederick	Rubin Frederick						hel Roberts					
0	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street	and Number or Flura	I Route No	mber City or Tow	n State Z	in Codel			
임	The state of the s												
- 1	20s. METNOD OF DISPOSITION	2517 B. NOLCHELII TRWY. / Balcimole, TD 21214											
	20b. PLACE AND DATE OF DISPOSITION  20c. METNOD OF DISPOSITION  20c. METNOD OF DISPOSITION    20c. LOCATION — City or Town, Stete  20c. LOCATION — City or Town, Stete  20c. LOCATION — City or Town, Stete  Camelery, cremetory or other place)  Garrison Forest At / Cem.  6/20  Owings Mills, MD												
3	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY												
- 1	March Funeral Home East												
	allnua Glolland   1101 E. North Avenue/Baltimore, MD 21202												
	28 FART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
- 1	snock, or heart fellure. List only one cause on each line.												
	disease or condition									Onset and Death			
	resulting in death) - a discount Cantellia										2 month		
	DUE TO (OR AS A CONSEQUENCE OF):												
Z													
은	Sequentially list conditions, If any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE O	T):								
3	cause. Enter UNDERLYING												
ERTIFICATION	CAUSE (Disease or Injury	DUE TO	(OR AS A CONSE	OUENCE OF	n:						-		
E	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  resulting in deeth) LAST							į					
S	d												
II	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY FINDINGS												
MEDICAL						ng coole grown i		PERFOR		240.	AVAILABLE PRIOR TO		
ă								1   YES 2	NO	1	OF DEATH?		
¥											1 TYES 2 NO		
÷	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
S	EXAMINER? / HOSPITAL: OTHER												
≥	1 PSPICE								ناب				
à	1 Metural 5 Dending (Month, Day, Year) INJURY					NJURY AT 26d. DEŞCRIBE NOW INJURY OCCURED WORK?							
B	1 Natural 5 Pending M 1 YES 2						S 2 NO						
0	3 Suicide 26e. PLACE OF INJURY — At home, ferm, street, fectory, off												
ш	4 Homicide determined building, etc. (Specify)							City or Town, State)					
ш	29e. CERTIFIER												
COMPLET	(Check only 1) CERTIFYING PNYSICI												
6	one) 2 MEDICAL EXAMINER	On the basie of e	ramination and/or	Investigatio	n, In my opinion,	death occured et th	e time, da	ite end place, an	d due to ti	he ceuse(e)	and manner ee stated,		
- 11	296. SIGNATURE AND TITLE OF CERTIFIER							1					
BE	100	elmon				29c. LICENSE NO	MER		ZVG. DAT		(Month, Day, Year)		
0	no much	1000043 June 15					12,1775						



DHMH-18 Rev 1/89



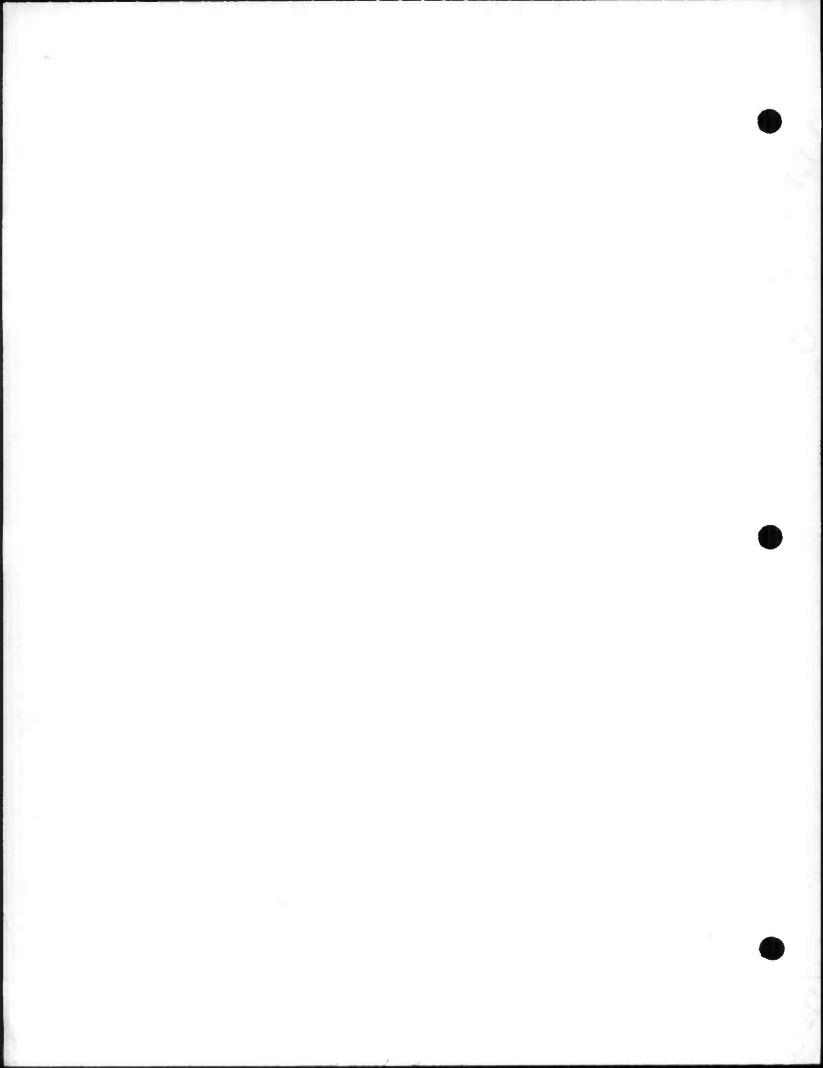
Item17,g-724,6-21-95,perf.h.,dk ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/30/95 t.t

transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 215-002 24 hours after death. Page 6 may be retained by the hosp TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hose TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE (	OF DEATH	IA.	YEAR 3	. TIME OF DEATH	
	VERNON  4. SOCIAL SECURITY NUMBER	LEROY		FLEET	SR.	JUN	E 18	,1995	5	23:05 P M	
	217-54-3510	5. SEX 6. A	GE (In yrs. last birthd 44 YR:	MONTHS DA		7. DATE (	7,195	· •	Couptry)	LTO, MD	
	9a. FACILITY NAME (If not institution, give a			WN OR LOCATION OF I		7,190					
DIRECTOR	96. COUNTY OF DEATH  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH  11/ a  18 DESIDENCE OF DECEMENT										
JEC.	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. II										
	MARYLAND		BALTI	MORE			LIMITS?				
3AL	10e. STREET AND NUMBER			101. ZIP CODE					AT COUNTRY?		
FUNERAL	630 N. FULTON AVENUE  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARI			21217					TED	STATES	
B	1 Nover Married 2 Married 3 Widowed 4 Divorced			MED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y  If yes, specify Cuban, Mexicen, Puerto Rican, etc.)  1 ☐ YES 2 ☐ NO Specify:					se or No— 14. RACE — American Indian, Black, White, etc. Specify: BLACK		
ditto.	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDEN	T'S USUAL OCCUI of work done durin	PATION	16b.	KIND OF BUS	SINESS/INDUS	STRY		
3	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NO	If use retired.)							
COMME	17. FATHER'S NAME (First, Middle, Last)			LABORER			unem	<u>a</u>			
S	LEROT FLEE	Leroy Fle	et			Maiden Sumeme) HOUSE					
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADDRESS (Str	et and Number or Rura				ode)		
Ĕ	MARY F LEET		11	.22 E.	20 THS	TREET,	BALT	IMORE,	, MAF	RYLAND #02	
	20a, METNOD OF DISPOSITION 1 □ Furial 2 □ Cremation 3 □ Rem	oval from Stata	20b. PLACE AND DA		(Name of	DATE	20c. LO	CATION — CH	ly or Town	, State	
	4 Donation 5 Other (Specify) KING MEMORIAL PARK 6-23 RANDALL STOWN, MD										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  WM. C. MARCH FH1101 E. NORTH AVENUE										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate interval Between										
	IMMEDIATE CAUSE (Fine)										
_	disease or condition resulting in death)  a. ALCOHOL AND DRUG INTOXICATION										
	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
2	cause. Enter UNDERLYING CAUSE (Disease or injury										
Ë I	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
E	d										
SAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY AND APPRICATE AND APPRICATE AND APPRICATE AND APPRICATE AND APPRICATE AND APPRICA										
MEDIC	CON								OMPLETION OF CAUSE		
Σ	DID TORACCO LISE CONTRIBUTE TO CALISE OF BEATH, MES TO NO TO AN ACCOUNT.								YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
SIC	EXAMINER? 1 STYES 2 NO	EXAMINER? HOSPITAL: OTHER:									
ž	27. MANNER OF DEATH	26a. DATE OF INJU (Month, Day, Ye.	RY 26b.	28b. TIME OF 28c. INJURY AT 28d.			8d. DESCRIBE HOW INJURY OCCURED				
BY	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation FOUND: 6-18-95			11:00 pM 1 YES 2XX NO U			UNKNOWN				
ED	3 Suicide 6 (C) Could not be	28e. PLACE OF INJ building, etc. (			TION (Street e Town, State)	Street and Number or Rural Route Number, State) 630 N. FULTON AVE.					
E,	FOUND: RESIDENCE BALTIMORE MARYLAND										
COMPLET	(Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner se stated.  2XXMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and menner se stated.										
BE C	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM			IBER 29d. DATE SIGNED			onth, Day, Year)	
0	IN MANUE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM			OCME				JUNE 19,1995			
	THE DUNAF M	V COMPLETED CAUSE OF						16	- 15	1 01005	
	31. DATE FILED (MONTE PROPER 100)	12 dedictions	HONATARA GARGO	renn S	treet, E	sa⊥ti	more	Mar	y1a:	nd 21201	
	JUN X T 1930   June 1930   Jun										

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND		HYGIENE REG. NO.				
	CTOR	1. DECEDENT'S NAME (First, Middle, Last) HAZEL FAI			2. DATE OF	2. DATE OF DEATN		3. TIME OF DEATH				
should		4. SOCIAL SECURITY NUMBER 2-16-01-0946  Se. FACILITY NAME (# not institution, give str	216-01-0946 10M2 DF 81 YRS.					20,19B	Count	Maryland		
1, 2, 3 sh		Good Samaritan Hos				n or location of i	DEATH	9c. CO	JNTY OF E	EATH		
Pages	DIRE	Maryland			ry, town on Lo Bal	cation timore			-	10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
n. ansit permit.	FUNERAL	100. STREET AND NUMBER 4111 Montana Aue				101. ZIP CODE 21206	10g. CF		WHAT COUNTRY?			
215-0020 attending physician. use as the burlal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			S. ARMED  13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea  [VNO It yes, specify Cuban, Maxican, Puarto Rican, stc.)					E – American Indian, ik, Whita, stc.		
T. 8 C	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a, DECEDENT'S (Give kind of life, Do NOT u	work done during	ATION most of working	16b. Ki	ND OF BUSINESS/IN	DUSTRY			
Nospiti sched	COMPL	9th Grade  17. FATNER'S NAME (First, Middle, Last)	9th Grade Medica						octor's Office			
# 8 4 X	l III	Herbert		Ange		fle, Malden Sumame)	Quinlin					
MARYL retained by the 5 should be at notified at	5	190. INFORMANT'S NAME (Type/Print)  Evelyn E. Schuster	(Daughtor)			et and Number or Rural	Route Number,		p Code)			
MORE, Page 6 may be director, page		20a. METHOD OF DISPOSITION  1 M Burlal 2 Cremation 3 Ramo  4 Donation 5 Other (Specify)	20b.	PLACE AND DATE stery, crematory, or of the try, crematory, or of the try, or of t	OF DISPOSITION	Ave Balt	DATE	Baltimo	City or To	own, Stata		
SALT death. e funera al. examil		21. SIONATURE OF FUNERAL SERVICE LICE			Sch	and address of Fi imunek Fu 5 Belair	neral	Home, In	2.			
be executed within 24 cian and completely fill for to burial, cremation aumatic event, the		IMMEDIATE CAUSE (Final	DUE TO (OR AS A	CONSEQUENCE O	F):	mode of dylng, au	ch aa cerdiad	c or reapiratory as	rest,	Approximata interval Between Onset and Deat		
the death certificate y the attending physical Mental Hygiene principle, or other tr	빙	thet initiated events resulting in death) LAST	DUE TO (OR AS A									
L KECOKI law requires that the absensigned by bept, of Health and 23 shows any is	AN: MEDICAL	PART II. Other algorificant conditions  CON 6 = 7 / V =  DID TOBACCO USE CONTR	S   NO	PERFORMED? 1 YES 2 NO			24b	. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO				
SICIAN: The law certificate has the State Dep	PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpa	16. PLACE OF DEA	OTHER:	ome 5 🗆 Raaldenca	8 Other (S	pec//v)				
NG PHYSICI frer this cer eath with th marked, o	BY PHY	27. MANNER OF DEATN  1 Netural 8 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED					
TTENDI TTOR: A after of	品	3 Suicide 8 Could not be detarmined	treet, factory, office  281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					Toute Number,				
型 本な =	COMPLET	29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
TO THE HOSP! TO THE FUNER be filed within IMPORTANT:	TO BE (	296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, D  DOG 7 1 5  DOG 7 1 5								
		30. NAME AND/WIDERESS OF PERSON WHO COMPLETED CAUSE OF DEATH (THEM 27) (TYPE, PHINI)  ALVIN SPINICS, M.D. GOOD SAM ARYTAN HOSPITAL										
	5	31. DATE FILED (Month, Dev. Year) 1995	32. REGISTRAR'S SIGNA	Rardall								



retained by the hospital or attending physician.

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30. NAME AND ADDRESS OF STEUS

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DOUGLAS JUNE 19, **GETNER** 1995 11:17P 4. SOCIAL SECURITY NUMBER 220-74-4863 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1-8-60 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 X M 2 - F 35 YRS. MD Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MD Baltimore Dundalk 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 7813 St. Clair Lane 21222 filled in by the funeral director, page 5 should be detached for use as the burial-transit on, or removal. USA 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicon, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 🕅 Never Married 2 🔲 Merried BY 3 Widowed 4 Divorced Specify: white 8 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16h. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) П College (1-4 or 5+) COMPL Truck Driver 12 0 Construction Co. once 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Charles Getner 75 June Clasing BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Getner 7813 St. Clair Lane, Dundalk, MD 21222 must be 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, State OATE 5 Other (Specify) Carmel Cemetery 6-23-95 Baltimore, MD medical examiner TURE OF UNERAL SERVICE LICENSEE 21, 510 22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. 23. PART I. Enter the diseases, or complications that daysed the death. Do not enter the mode of dying, such as cerdiec or respiratory street, shock, or heart failure. List only one cause on each line. Approximate Interval Between 6 IMMEDIATE CAUSE (Finel **Onset and Death** the cremation, disease or condition ZEPSIS WEEK traumatic event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF). hysician and com prior to burial, ANCREA-TITIS CERTIFICATION Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF) the attending physician Mental Hygiene prior tr cause. Enter UNDERLYING CAUSE (Disesse or Injury or other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL signed by the Gall Stones shows any 1 TES 2 NO OF DEATH? MODERATE Alcohol consumption 1 TYES Z NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IN UNCERTAIN I PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem certificate ? HOSPITAL:
1-4 Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO marked, or 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED this ( 1 Natural 5 Pending м 1 YES 2 NO BY After death Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 69 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be DIRECTOR: Jours after ( 4 Homicide determined 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. COMPL (Check only one) TO THE HOSPITAL

TO THE FUNERAL I

De filed within 72 h

IMPORTANT: If II 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurs at the time, date and place, end due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF

MD, PhD

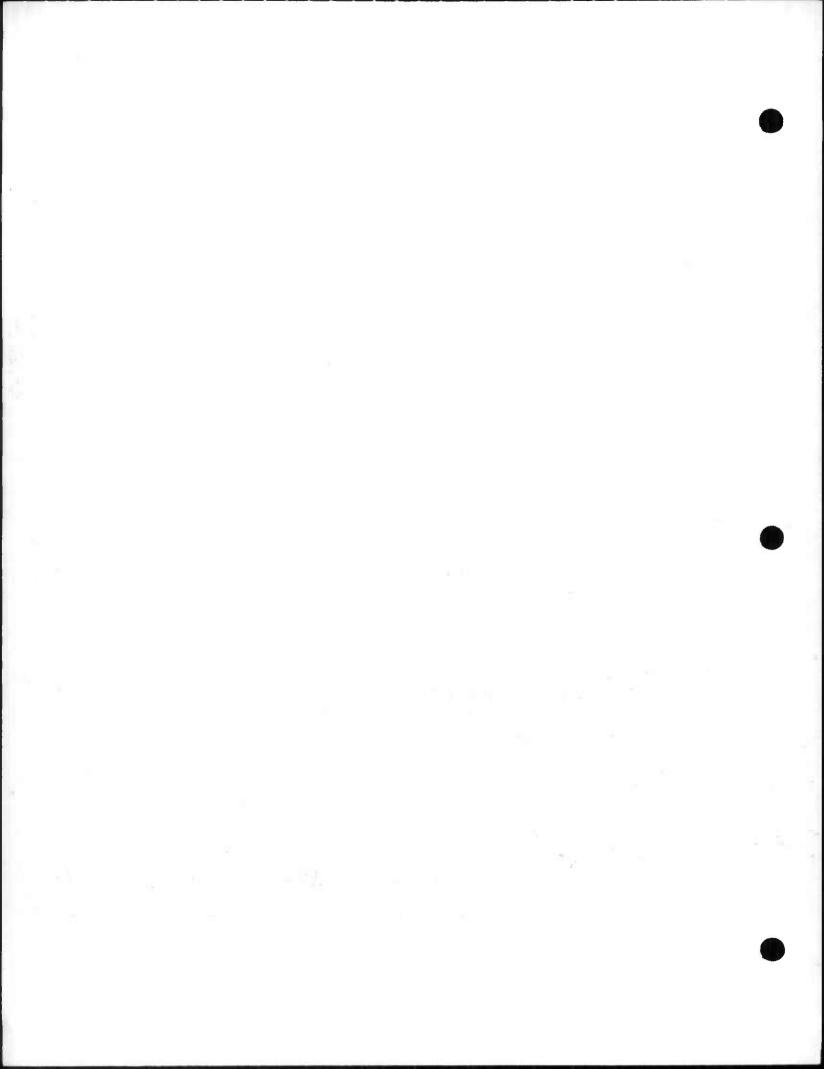
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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S Devoler Re 29c. LICENSE NUMBER

June

29d. DATE SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

AL OF MILITARING FILL SOUTH STATE OF THE STATE OF THE UPS DECUMENT OF THE STATE OF THE STATE OF THE TOSPITAL OF ATTENDING PRYSCHAIN.	ial-trans	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME /First Middle Last 2. DATE OF DEATN 3. TIME OF DEATH VEAR LOUISE GILLIAM R. 12:15P 995 JUNE 9 4. SOCIAL SECURITY NUMBER BIRTIN Day, Year) 5 REY 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign 1925 JUNE 1 M 2 TKF 223-32-5377 VIRGINIA 69 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN SC COUNTY OF DEATH DIRECTOR 1000 N. EDEN ST. BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE CITY 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1000 N. EDEN STREET 21213 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES X 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexicon, Puerto Ricen, etc.) BY 1 TES 2 NO Specify: Specify: 3 Widowed 4 Divorced BLACK 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 10TH HOUSEWIFE N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumame) RICHARD GILLIAM, SR. NANNIE REDD BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BERNICE TAYLOR CAROLINE ST. BALTO, MD. 9 20a. METHOD OF DISPOSITION

1X Burlel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State BALTIMORE CEMETERY 6/24/95 BALTO, MD 4 ☐ Donation 6 ☐ Other (Specify) 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23. PART I. Enter the diseases, or Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition resulting in death) CONGESTIVE NEXT FAILURE DMINUTES DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that Initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 TO NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) 3honder Phylai, MD 6/19/95 M6104 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

WONDER PURYEAR, 600 N. WOLFE STREET, 110 N. TOWER BUILDING BOLTO, MO

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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30 NAME AND ADDRESS OF PERSON WHO COMPLETED CALLE OF DEATH (ITEM 27) (Type, Print)

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432. REGISTRATE SIGNATURE

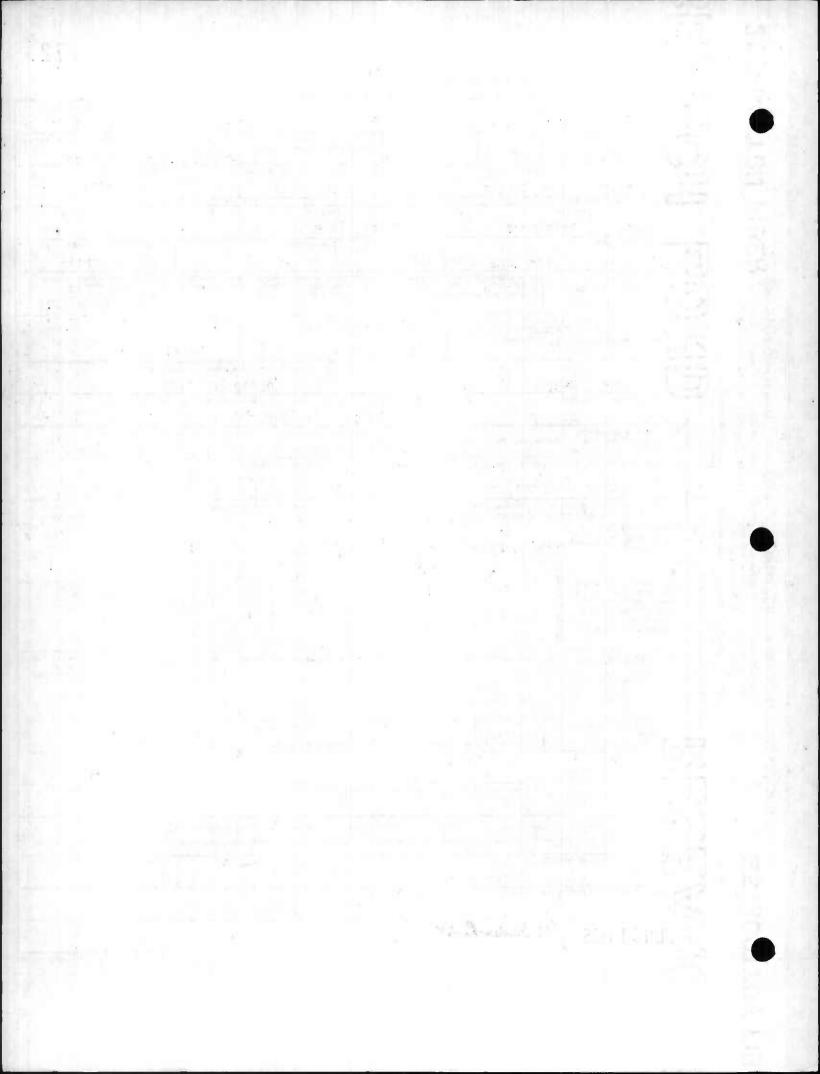
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OR ATTENDING PHYSICIAN: The

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Marguerite Gottschalk 18 1995 2:30 am June 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) October 20, 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 XF 98 217-20-6661 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore Charlestown Care Center Catonsville RESIDENCE OF DECEDENT 10a. STATE 16b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2 X NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 711 Maiden Choice Lane Apt. 1704 21228 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (X) NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried 1 YES 2 X NO Specify: BY 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher Elementary/Secondary (0-12) College (1-4 or 5+) 6 Salesperson Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Sumame) John Hammer Louise Schneider BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code, 5 Mrs. Mary Cashour 701 MacPhail Court-North Belair, Md. 21014 20e, METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Most Holy Redeemer Cemetery 6/20/9\$ Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna 22. NAME AND ADDRESS OF NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. Mark T. Zaroggin 5305 Harford Road Baltimore, Md. 21214 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Finel Onset and Death in the (tent mestere disease or condition resulting in death) moult DUE TO (OR AS A CONSEQUENCE OF): sterone ylong CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF)reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? MEDICAL rell tim 1 TYES 2 NO Shows 1 TYES 2 THO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA **EXAMINER?** OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b, TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural м DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rurel Route Number, City or Town, Stets) 6 Could not be COMPLETED 4 Momicide 29e. CERTIFIER
(Check only one)

The Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) en D264

711 MAIDEN CHOICE LANE 2727A

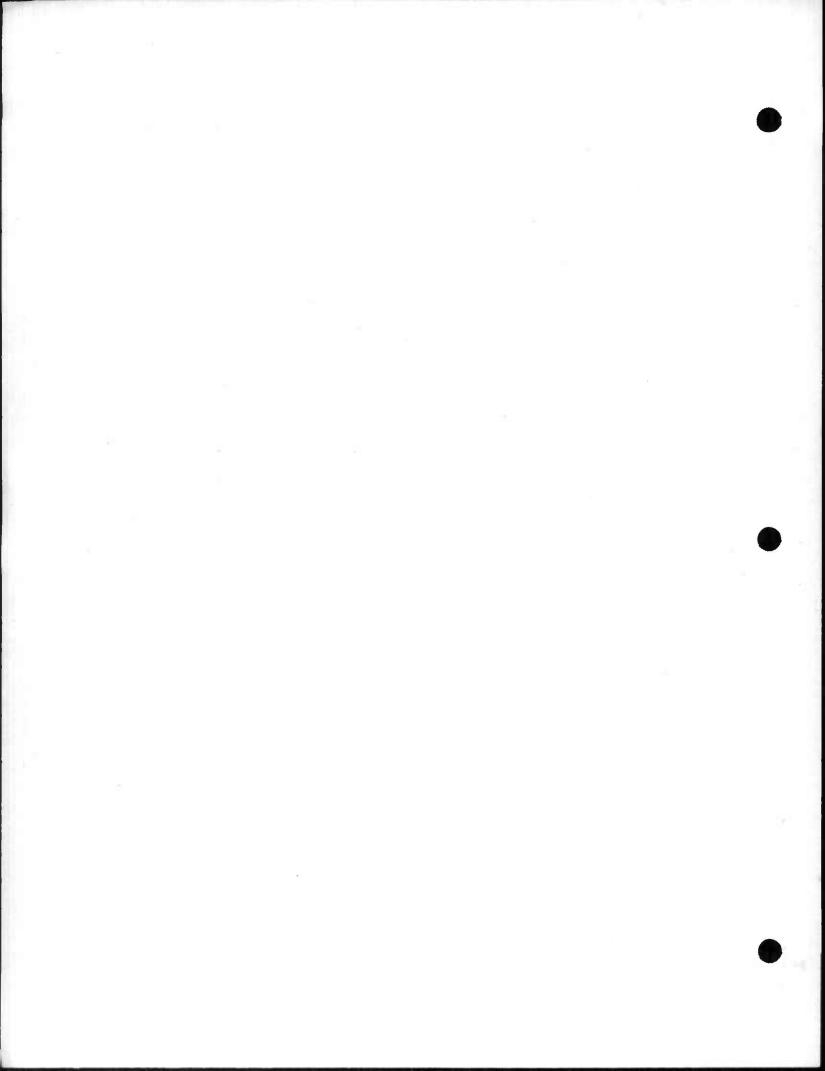


DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the to the filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traus

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAN				SHIII	ICALE	- 01	DEA	111	H	REG. NO.			
	1. DECEDENT'S NAME (First		Joseph	Но	fmei	0 + 0 =	C==			2. DATE OF	DAY		YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. les							19,1	-		6:00 P M
,	216-03-4		1 ∰ M 2 ☐ F	80	YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE OF I (Month, De 3-2	BIRTN ny, Year) 7-15		8. BIRTNP Country)	LACE (State or Foreign
	9a. FACILITY NAME (If not in			9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATN					9c. COUN	TY OF DE			
TOR		nings Lane Baltimore Baltimore								ore				
EC	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										1	10d, INSIDE CITY		
DIRECTOR	MD Baltimore Baltimore									- 1	LIMITS?			
FUNERAL	9130 Lenn		ane			101. ZIP CODE 21237						10g. CITIZ	EN OF WH	AT COUNTRY?
11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea of If yea, specify Cuban, Maxican, Puerto Rican, etc.)								or No-	14. RACE - Black.	- American Indian, White, etc.				
В	IF YES GIVE WAR OR DATES"								white					
	(Specify only	EDENT'S EDUC y highest grade (	ATION completed)	(G	CEDENT'S	vork done i	CCUPATIO	ON st of working	19	16b. KIN	D OF BUS	NESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Do NOT us	,						1 D		
NO N	17. FATNER'S NAME (First, M	iddle, Last)	- 0		Sales	sman		16. MOTE	HER'S NAM	Na.1		1 Bre	ewin	g Co.
BE C	Wolfgang H	Hofmeis	ter							berl	o, marcon c	un nemo)		
10	John J. Ho		er Jr.	190						oute Number C			Code) L237	
	20a, METNOD OF DISPOSITI	ION n 3 🗆 Remo	val from State	20b. PLACE	NDDATE	OF DISPOS	ITION (Na	me of		DATE	200 1.00	ATION — C		n, State
	4 ☐ Donation 6 ☐ Other 21. SIGNATURE OF TUNERAL		MOSE	Dr	uid E	Ridge	Cei	neter	у 6-	22-95	Pi	kesvi	ille,	MD
	· S- ),	MAA.	8 7	Un		22.	Cva	ch/Ro	seda	lle Fur Ave.	neral	Home	9	
	23. PART I. Enter the di	seases, or co	omplications the	t caused the de	ath. Do n	o1 enter					or reapire	atory arre	at.	Approximate
	shock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	Bart Isilure. L	iat only one ceu	Me das	tul		0 1	0 0		Canc				Interval Between Onset and Death
			DUE TO	OR AS A CONSEC	DUENCE OF	7):	ت الراب	de la			-			
NO.	Sequentially list conditi	ons,		(OR AS A CONSEC	DUENCE OF	7):								
<u>S</u>	cause. Enter UNDERLYI CAUSE (Disease or inju	NG												
CERTIFICATION	that initiated eventa resulting in death) LAS	т	. DUE 10	(OR AS A CONSEC	DUENCE OF	7):								
	PART it. Other algoritica	nt conditions	contribution to	death but not a	a multilana (	- 4h								
EDICAL	and the state of t	THE CONDITIONS	contributing to	Geetii Dat not n	emunning i	n the un	oeriying	g cause g	liven in F		PERFORM	ED?	1	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE
										_   ' [	YES 2	MO	9	F DEATH?
Σ	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF DEA	TH YE	SEI	NO [	UNC	ERTAIN				'	YES 2 MO
ĕ	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			E OF DEAT	N (Check o	only one)						_	
XSI	1 TYES 2 DA		HOSPITAL:	ER/Outpatient 3	□ DOA	4 Num		6 ₽ A6	aldence (	5 Other (Sp	ecify)			
BY PHYSICIAN:		Pending investigation	26a, DATE OF (Month, D		28b. TIMI INJ	E OF URY M	26c. INJ WO 1 🔲 Y	RK?		28d. DESCRIE	BE NOW IN	JURY OCCU	RED	
100	3 Suicide 6	Could not be	26e. PLACE O building,	F INJURY — A1 hor etc. (Specify)	me, farm, a	treet, facto	ory, office			281. LOCATION	N (Street an wn, State)	d Number of	r Rural Roc	rte Number,
9	29a. CERTIFIER													
COMPLETED			IAN: To the best of											ind manner ea stated.
H	29b. SIGNATURE AND THLE	OF CERTIFIER	mD	5				29c. LICE	NSE NUMI	BER 487		29d, DATE	SIGNED A	fonth, Dey, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM		_	1/20	1 110	10	2.0	0	0017	71 1	1720
	31. DATE FILED (Month, Day, 1	_ / /	22. REGISTRA	P SIGNATURE	1 5	<u> </u>	IVE	cin	26	·()) &	K ,	19/14	, 10	y 6765
	TONE T 199	0												

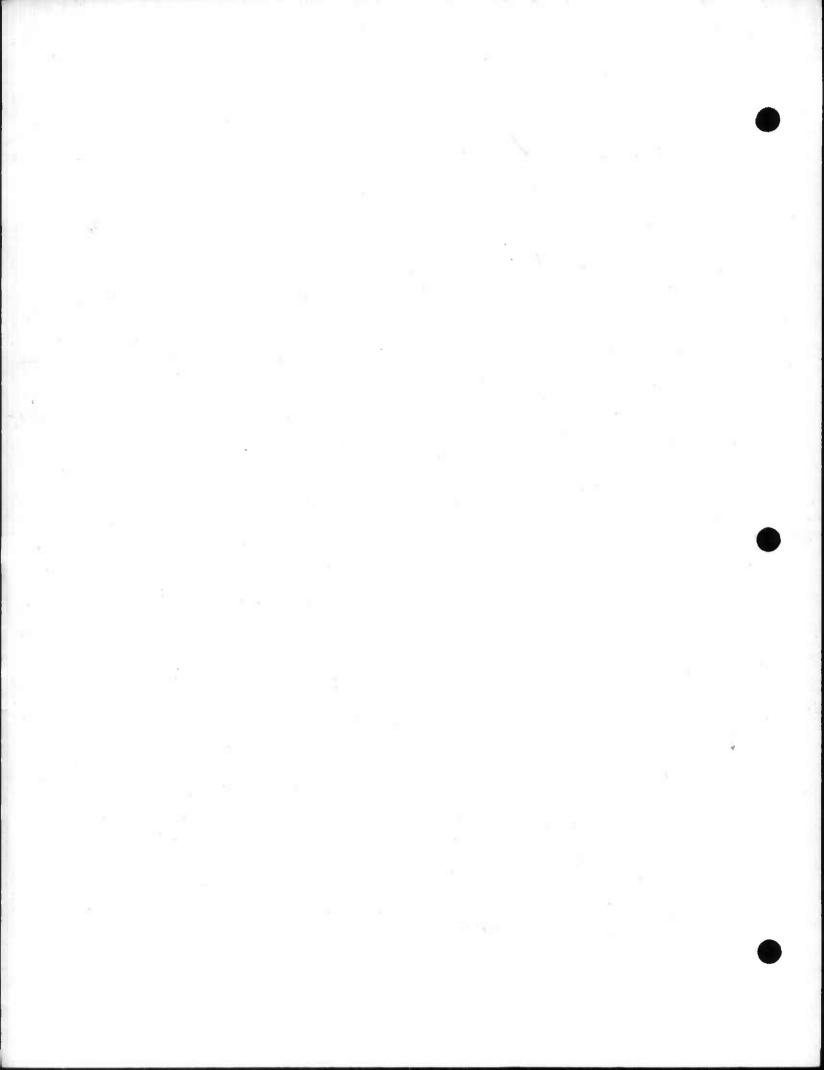


DIVISION OF VITAL RECORDS, P.O. BOX 68760

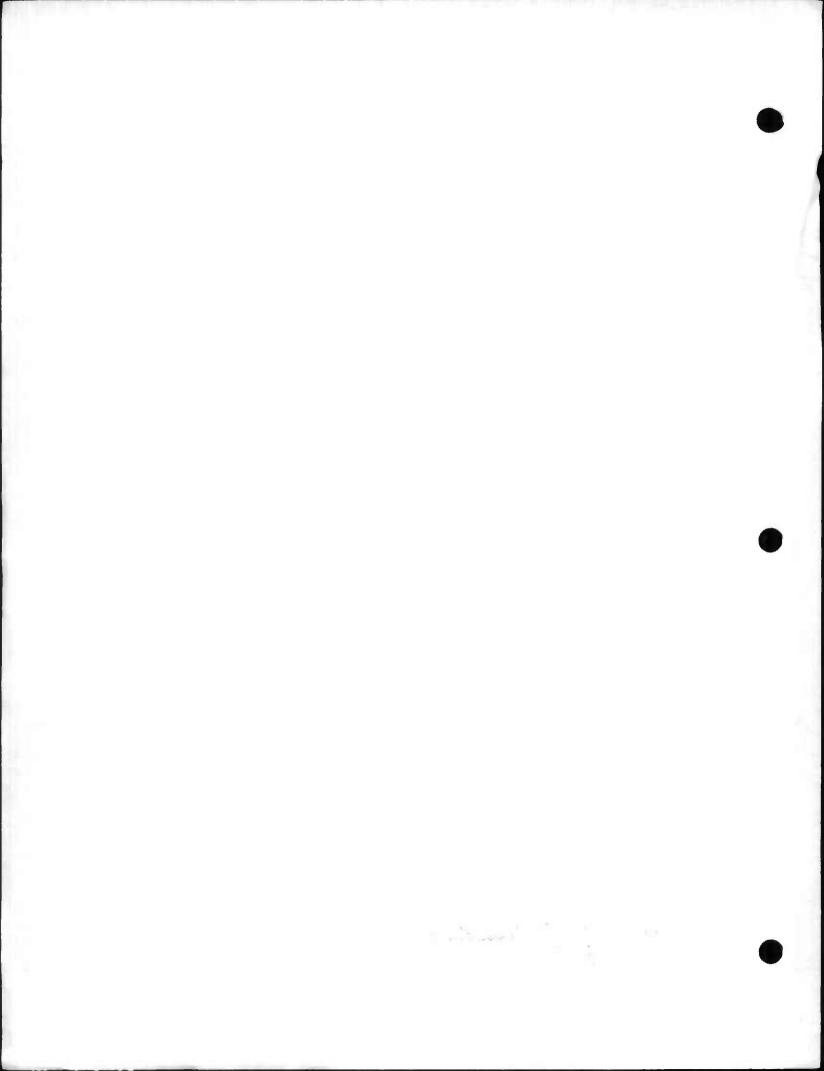
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained TO THE FUNESTAL DIRECTIOR: After this exertificate has been signed by the attending physician and completely filled in by the funeral directior, page 5 shoult be filed within 72 hours after death with the State Dept. of Health and Mertial Hygiene prior to burial, cremation, or removal.  IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG.	NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT		3. TIME OF DEA	TH
	ROBERT			.Т.	AMES	JUNE 7	1005	10:30	Ам
		5. SEX/ 6. AGE (I	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTNPLACE (State or F	
	219-34-0747	1 M 12 0 F 70		ONTHS DAYS	HOURS MIN.	Aules 10	1015	Country)	urungii.
	Be. FACILITY HAME (If not institution, give stre			N. OITY TOWN	201001101101	1	1713	unk	
oc	The second of the second of the second	et and number)		BE CITY, TOWN	OR LOCATION OF E	EATH V	9c. COUNTY	OF DEATH	
2	2503 VIOLET AV	<u>ENUE #1003</u>		BALT	IMORE				
E I	10a, STATE 10b, COUNTY		str. Arv	TOWN, OR LOCA	TION			day mining out	
DIRECTOR	Maguland		121	11				10d. INSIDE CIT	
	10e. STREET AND NUMBER		1	HIM				t D TES 2	NO
A A	3203	- An A	+ 1003	4 10	I. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?	
9	0303 VIDIE!	170e.14	1. 1005	A	×12/1	5	U	, D, M.	
FUNERAL	t1. MARITAL STATUS  t Never Married 2 Married	12. WAS DECEDENT EVEN IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify en, Puerto Rican, etc.	Yes or No- 14	. RACE — American Ind Black, White, etc.	lan,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 TNO Speci			Specify 2 1	1
								DIAC	
ED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION (mpleted)	16e. DECEDENT'S US (Give king of wo	rk done durina me	ON ost of working	16b. KIND OF	BUSINESS/INDUS	TRY	
۳	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)		1 1	1/		
COMPLET	un K.		M	MC	noun		n/sn	own	
<u> </u>	17. FATNER'S NAME (First, Middle, Lest)	2.4			18. MOTHER'S N	AME (First, Middle, Me.	den Sumame)		
ш	L WY KY	10WM				n Kn	nwn		
0	19a. INFORMANT'S NAME (Type/Print)	1	19b. MAILING A	DDRESS (Street	and Number or Rural	Route Number, City or	Town, State, Zip Co	deta .	
۱ ۲	( Appince WI	le R	2501	Viole	+ Die	Apt 13	atal 1	RAHO MY	2/1/
	20s. METHOD OF DISPOSITION	dot	PLACE AND DATE OF	.,,,,,	1700	GATE 200	NOCATION — CITY	JAIIO IIA	J. O.
	1 Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	al from State	mary, creshatory or other	r plece)		17	ACCEPTANT OF THE	y or Town, State	1
	21. SIGNATURE OF FUNERAL SERVICE LICEN	150	es lern	THE	len.	6/191	HIONS	VILLE IN	7
	. 61	72 (1)		MAR	Sh All	W. Jone	5 16	FHICH	,
	Denia a	NAme X E	Sh a	dia	1		RAI	4 m/ >	1224
	23. PART I. Enter the diseases, or col	mplications that caused	the deeth. Do no	enter the mo	ds of dving, su	ch as cardiac or n	entratory errest	Approxim	المحام
	SHOCK, OF NASRY TAILURE. LIE	at only one couse of an	ch line.				opilition, siles.	interval E	etween
- 1	iMMEDIATE CAUSE (Final disesse or condition	1000		01000	1/4 0 00 . 1	110 0		Onset an	d Desth
	resulting in death) a.	ARTERIOSCI		CARVIC	VASCUL	MY VISE	ase		
- 1		DUE TO (OR AS A	CONSEQUENCE OF):						
5	Sequentially list conditions, b.								
Ĭ .	If any, leading to immediats	DUE TO (OR AS A	CONSEQUENCE OF):					!	
HILLCALION	CAUSE (Disease or Injury								
<u> </u>	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
C E	d.								
2	PART II. Other aignificant conditions	contributing to death by	it not requiting in	the restortule	a course obuse to	Post I as una	No. of the last of		
₹		contributing to death bu	it not resulting in	trie underlyin	g cause given in	Part I. 24a. WAS PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY F AVAILABLE PRIOR	10
5	-					1 XYE	3 2 NO	COMPLETION OF OF DEATH?	CAUSE
N N						`		1   YES 2	NO
	DID TOBACCO USE CONTRI	<b>BUTE TO CAUSE OF</b>	DEATH YES	□ NO □	UNCERTAI	N 🗆			
FITSICIAN	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH	(Check only one)					
5		HOSPITAL:		THER:	s SY Besidence	6 Other (Specify)			
	27. MANNER OF DEATH	26e. DATE OF INJURY	28b. TIME		URY AT	26d. DESCRIBE NO	M INTERN OCCUR	nED.	
-	1 Natural 5 Pending	(Month, Day, Year)	INJUF	Y WC	PRK?				
5	Accident Investigation	28e. PLACE OF INJURY	- At home term etc			and together to			
3	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	(y)	HPE, INCOME, OTHE	•	261. LOCATION (Str. City or Town, St	eet end Number or i ete)	Rural Route Number,	
	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, death occurred	et the time, date	end place, end due	to the cause(e) and	menner ee stated.		
CMTLE	2 MEDICAL EXAMINER:	On the basic of examination	end/or investigation,	in my opinion, d	eath occured at the	time, date and place	end due to the co	suse(e) end manner se s	tated,
ا د	286 SICHATURE AND TITLE OF CERTIFIER	MODE			29c. LICENSE NU	MAED	I and pare of	101100 #1 # 0 # 1	
	7 1 0/2	IN A	. 1		O.C.			IGNED (Month, Day, Year) VE 8, 199	5
ון מ	Minde	CV X V				[7] . [7] .			
2	30 NAME AND ADDRESS OF DESCRIPTION	acc	<u> </u>		0.0.		1 001	VE 0, 193	, ,
2	110000000000000000000000000000000000000	COMPLETED CAUSE OR DEA							
2	MARIO F GOLLE	JR MO1	11 Penn					and 21201	
2	MARIO F GOLLE	4 / //-	11 Penn						



		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF			YGIENE EG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	1-				2. DATE OF D	DEATH	3	. TIME OF DEATH
		Edward JOHA	Katura				Jun e	15	95 YEAR	5:35 AN
Ð		4. SOCIAL SECURITY NUMBER 2011. 218 03 9986	5. SEX 6. AGE (	(In yrs. last birthday, YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day 02 04	( Year)	6. BIRTHPL Country) Maryl	ACE (State or Foreign
phous	Œ	9a. FACILITY NAME (If not institution, give s				OR LOCATION OF E	DEATH		NTY OF DEAT	
2,3	CTO	University of A	Maryland Hosp	pital	Baltin	nore		1	A/N	
Pages 1	l III l	10a. STATE 10b. COUNTY		10c. CI	TY, TOWN OR LOCA	ATION			10	Dd. INSIDE CITY
# 2	DIR	Md. N/	4	Ba	ltimore				X	LIMITS?
n. Insit permit.	ERAL	307 Elrino Str	reet		10	21 224		10g. CITI		AT COUNTRY?
21215-0020 If or attending physician. Nor use as the burial-transit	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☑ YES IF YES, GIVE WAR OR DA	2 NO	If yes, s	CENDENT OF HISPA pecify Cuban, Mexic S 2 NO Spec	an, Puerto Rican	ecify Yes or No— , etc.)		American Indian, Yhite, etc.
rtendii		15. DECEDENT'S EDUC		16a. DECEDENT	S USUAL OCCUPAT	ION	16h KINI	OF BUSINESS/IND	White	
F 5 3	ETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of life. Do NOT	work done during m	ost of working	TOOL KING	OF BUSINESS/INL	OSINI	
	COMPL		4	Procur	ement		Aer	ospace		
MARYLAND retained by the hospit 5 should be detached notified at once.	8	17. FATHER'S NAME (First, Middle, Last)						, Maiden Surname)		
MARYLA retained by the 5 should be det otified at on	BE	Joseph Kabara  19a. INFORMANT'S NAME (Type/Print)					ine Cza			
	2	Margaret F. Kab	ara	307	G ADDRESS (Street Elrino S	t. Balto	Aoute Number, Co., Md. 2	lty or Town, State, Zip 21224	Code)	
TORE e 6 may ector, pa		20a. METHOD OF DISPOSITION  1 Burial 2 Cremation 3 Remo	oval from Stata cem	etery, crematory or	OF DISPOSITION (Nother place)		DATE	20c, LOCATION —		
Page (direc		4 Donation 5 Other (Specify)	ENSEE 1	Stanis	laus Com	0− I		Baltimo	re,Md	•
BALTIMORE, after death. Page 6 may be by the funeral director, page smoval.		► Charles )	J. Zuler		Char	les S. Z	eiler &	Son Inc	• ,	
24 hours filled in to on, or rei		IMMEDIATE CAUSE (Final disease or condition	List only one cause on ea	ach line.	not enter tha me	ode of dying, au	ch aa cardiac	or reaplicatory arr	eat,	Approximate interval Between Onset and Death
		resulting in death)	DUE TO (OR AS A	CONSEQUENCE	OF):	-				11
C68760 executed with and complete burial, creater matte even	N	Sequentially list conditions,	Renal							12 Weeks
De ed lor to aum	ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE	DF):					6
B( fificate physii ne pri	FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE	OF):					
S, P.O. BOX death certificate be e attending physician ental Hygiene prior to rry, or other traum	CERTIFICATION	resulting in death) LAST	1.		,					
S, e de de de de de de de de de de de de d		PART II. Other significant condition	contribution to death be	ut not requiting	in the underlyin	a sause about la	Post I I a			
	MEDICAL		- Contributing to death bi	ot not resulting	in the underlyin	ig cause given in		PERFORMED?  YES 2 NO	AM CO	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
AL RECOF he law requires that has been signed I e Dept. of Health a		DID TODA COO HOT CONTROL				1			1	VES 2 NO
ITAL I	SICIAN:	DID TOBACCO USE CONTR			ES   NO		N 🗆			
F VITAL SICIAN: The law certificate has the State Dep	Sic	EXAMINER?	HOSPITAL:		OTHER:		N = OF			
OF V PHYSICIA this certif with the feed, or	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. Til		ne 5 Rasidenca	1	city) E HOW INJURY OCC	TURED	
NG PHYSI fler this c eath with marked,	ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, Year)	IN	JURY W	YES 2 NO		- 110W 11100111 000	ONED	
TTEND TTOR: A after d	ETED B	3 Suicide 6 Could not be detarmined	26s. PLACE OF INJURY building, etc. (Speci	— At home, farm,	street, factory, offic	Ca	28f. LOCATION City or Tou	(Street and Number rn, State)	or Rural Route	e Number,
Te Die	Ä	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	ados, desth occur	rad at the time, date	and place, and du	to the secondar			
E AC =	COMPL	2 MEDICAL EXAMINE	R: On the basis of exemination							d menner as stated.
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITLE OF CERTIFIER	20		10	29c. LICENSE NU	MBER			onth, Day, Year)
THE THE PORTINE	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED ALLOS OF		110	108	550	1 6	,-15	- 95
		Scoth M	ETTE alles be	79 Z	2 Sucre	6 000	in 5th	est, Bal	ti mar	e MO
		31. JUN 21111995 Ja	3 EGE BAR'S CM	ZOBS.				,		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

Item1 Film724,6/21/95.1t
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOHN HENRY KEHRING, JR 1995 JOHN H. KEHRING June 20 4:15 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Dey, Year) 06 19 20 B. BIRTHPLACE (State or Foreign Country) Maryland Masyland IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS MIN. 215--01-2519 1 XM 2 - F 75 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH V.A.M.C. -Perry Point DIRECTOR Cecil Perry Point RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Md. Essex permit. TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 82 8620 Kelso Drive Apt.302A 21221 in and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☆ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, atc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married ΒY 3 Widowed 4 Olvorced W.W.2 White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Kimble -Tyler Co. Unknown Cooper 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) John Henry Kehring Sr. Anna Brundick BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary A. Kehring 8620 Kelso Drive Apt. 302A Essex, Md. 21221 be 20e. METNOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Loudon Park Cemetery 0-23 6-23-95 Balto., Md. Donation 6 - Other (Specify) \_ 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler & Son Inc. hours after death. 6224 Eastern Ave. Balto., Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feilure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition Septicemia Due to resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF): traumatic La Infected Right Heel Ulcer
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate the attending physician I Mental Hygiene prior to the death certificate be cause. Enter UNDERLYING Diphtheroids and Providencia stuartii CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24a. WAS AN AUTOPSY Health and any Diabetes Mellitus, Prostate cancer, 1 - YES 2 NO OF DEATH? 1 TES 2 NO Parkinson's Disease of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: . OR ATTENDING PHYSICIAN: The law of DIRECTOR: After this certificate has be hours after death with the State Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL OTHER:
4C Nursing Nome 5 Residence 6 Other (Specify) 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetlant 3 | DOA 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident м 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 ETED. 6 Could not be 4 Homicide 28 29a. CERTIFIER
(Check only one)

The Desire of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL E FUNERAL D d within 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SANATURE AND TITLE OF CERTIFIER

AND CA 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Santas 151094-1 MI 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MELECIA SANTOS, M.D., VA Medical Center, Perry Point, MD 21902 32. REGISTRAR'S SIGNATURE 1995

X

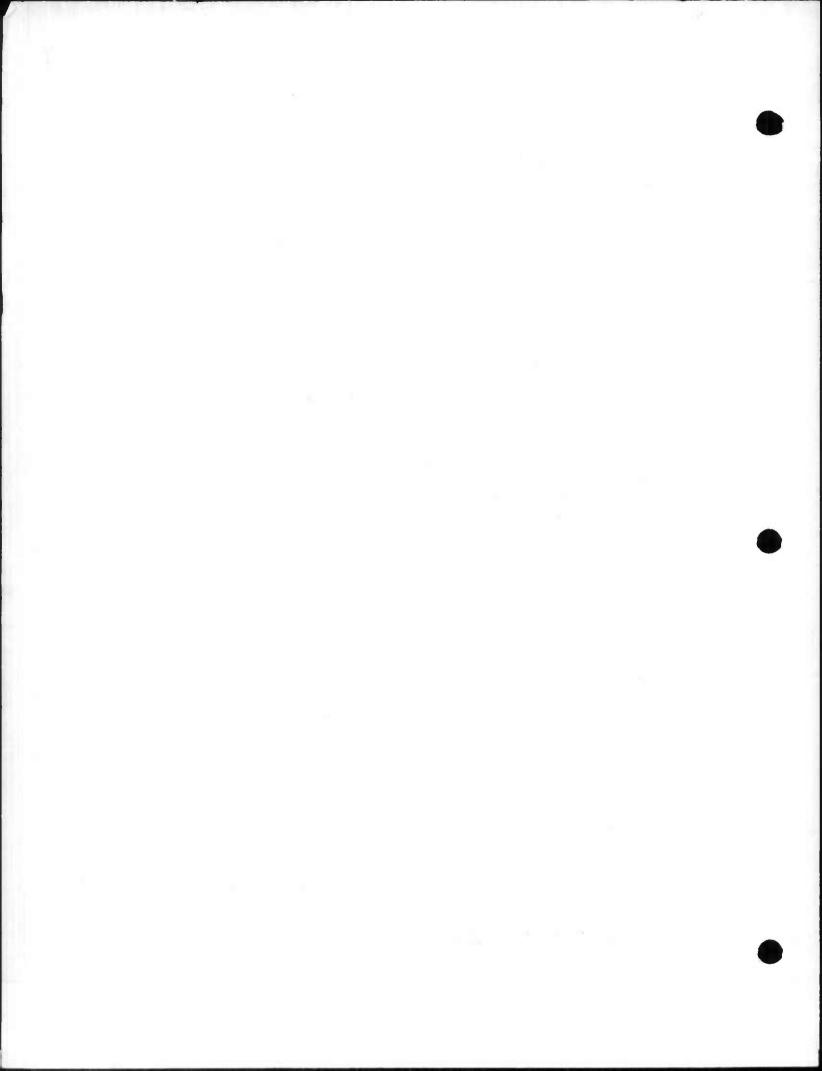
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Panes 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. OECEDENT'S NAME (First	, Middle, Last)	. )							2. DATE O				3. TIME OF DEATH
	LEON		KIEDR	Sow	ICZ	1				JON	E	ר"ו	1995	2:35 "
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In y	rrs. last birthday	MONTHS	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	FBIRTN			LACE (State or Foreign
	212-30-2430		1 🕅 M 2 🗌 F	8	35 YRS.					08%	3/09		Po1	and
œ	Se. FACILITY NAME (If not in							OR LOCATI	ON OF DE	EATH .			NTY OF DE	ATN
DIRECTOR	Good Samar:	LTAN H	cspital			Ba1t	imo	ore					N/A	
H H	10a. STATE	10b. COUNTY	r		10c, C	ITY, TOWN C	OR LOCA	ATION						IOd. INSIDE CITY
	Maryland		N/A		Ba	1timo	ore							LIMITS?
₹ I	10a. STREET AND NUMBER						10	of. ZIP COD				10g. CIT	ZEN OF WH	IAT COUNTRY?
FUNERAL	2914 Over:	Land A						2!2:				L	US	
	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES :	2 NO		Il yes, s	pecify Cube	n, Mexica	NIC ORIGIN? In, Puerto Ric	(Specify Yea an, atc.)	or No-	14. RACE - Black,	- American Indian, White, etc.
B	3 Widowed 4 Divo	rced	IF YES, GIVE V	WAR OR DATE	S		1 YE	S 2X NO	Specify	y:			Specify W	nite
COMPLETED	15. DEC (Specify onl)	EDENT'S EDU	CATION completed)	16	Give kind o	S USUAL O	CCUPAT	ION		16b. K	IND OF BUS	INESS/INC		
9	Elementary/Secondary (0		College (1-4 or 5	+)	ille. Do NOT	use retired.)	uuring m	OSI OF WORK	rg					
₽ B	7th.				Butch	er					eat Fa		У	
										ME (First, Mic				4
BE	Jan Kie		CZ		10h MAH 0	G ADDRESS	(Street			ania I				
2	Ewa Kied	rowic	7.							1timor				1214
1	20s. METHOD OF DISPOSIT	ION			ACE AND DATE	E OF DISPOS			. Da.	OATE			City or Town	
	1 X Buriel 2 Crematio 4 Donelion 5 Other	(Specify)		- cemeter	oly Ro	other place) Sary	Cen	etery	7	6/21	Ba:	Ltimo	ore, N	Maryland
	21. SMINATURE OF FUNERA	L SERVICE UT	There Is	11	1			ND AOORE		r Fune			,	
	Vac	-2//	4.1h	48		40	)1 S	. Che	estei	r St.	Balt:	imore	Md.	. 21231
	23. PART i. Enter the di	seasea, or o	omplications the	t caused th	e deeth. Do	not enter	the m	ode of dyl	ing, auci	h aa cerdia	c or reapli	ratory arr	rest,	Approximata
į	IMMEDIATE CAUSE (Fin		List only one cat	ise on each	ı ime.									Interval Between Onset and Death
	diseese or condition resulting in death)	<b>→</b>		EPS										7-10 DAYS
					NSEQUENCE			/ > /		_				
<u> </u>	Sequentielly list conditi	iona,			OO I	OFI:	AN	GRE	ENE	7				1
CERTIFICATION	if any, leading to immediate. Enter UNDERLY	NG				,								
	CAUSE (Disease or Inju		DUE TO	(OR AS A CO	NSEQUENCE	OF):	-							
	resulting in death) LAS		d											
- 14	PART II. Other algnifica	nt condition	a contributing to	deeth but i	not resulting	in the un	derlyin	g cause g	iven in	Part i. 2	4a. WAS AN		24b. V	VERE AUTOPSY FINDINGS
MEDICAL	CORONE	1RY	ARTEI	RY_	D150	EASL				١,	PERFOR	-	1 0	MAILABLE PRIOR TO COMPLETION OF CAUSE
ij														F OEATH?
ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF [	DEATH Y	ES 🗆 N	10 E	UNC	ERTAIN	V 🗆				
5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF OE	OTHER								
PHYSICIAN:	1 YES 2 NO		1 (Anpatient 2		_	4 🗆 Num	ing Hon		sidence	6 Other (	Specify)			
		Pending	26a. DATE OF (Month, D		28b. Ti	ME OF IJURY	W	JURY AT	140	28d. OEŞCF	RIBE NOW IN	JURY OCC	CURED	
BÁ	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	nvestigation	26s. PLACE O	FINJURY —	At home, farm		1 🗌		NO	261 LOCAT	ION (Street a	nd Mumber	or Presi Por	do Musico
		Could not be determined	building,	atc. (Specify)			,,			City or	Town, State)	no mumber	or nurar not	Nomber,
ן ב	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledg	e, death occur	red at the ti	me dete	and place	and due	to the cause	(a) and man		24	
COMPLETED	one) 2 MEDI	CAL EXAMINE	R: On the baels of e	camination an	d/or investigat	lon, in my o	pinion, d	desth occur	ed at the	time, date en	d place, and	due to th	e cause(s) e	nd manner es stated.
E C	29b. SIGNATURE AND TITLE			15					NSE NUM					fonth, Day, Year)
2	- N	May	alup	<u>u</u>	1	1.0		Po	286	236		N-	NE	17, 1995
- [	30. NAME AND ADDRESS OF	PERSON WIT	COMPLETED CAUS	E OF OEATN	(ITEM 27) (Typ									
	MAYA	GUPT	A			(	36	do	DAN	MARIT	AN .	Hosi	ATI	
	JUN 2 1 1991		III. REGISTRA		RE									
	JUN Z I 199	HUH	of the state of th	MINOR.MI										



e executed within 24 hours after death. Page 6 may be retained by the hos	in and completely filled in by the funeral director, page 5 should be detach to burial, cremation, or removal.	umatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

It	em19a,Fi1m724,6/21	/95,lt									20	1	
	1 - STATE REGISTRAR	STATE OF I		/ DEPAR					MENTAL	HYGIEN REG. NO.	E		
	1. DECEOENT'S NAME (First, Middle, Last)									OF OEATH			. TIME OF OEATH
	JOHN HENRY LINDS	SAY							JUN	E 18.	199	5 YEAR	3:25 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE O	F BIRTH		8. BIRTHPL	LACE (State or Foreign
	212-72-7815	1 Q # 2 □ F	36	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Dey. Wear)	1958	MAR.	YLAND
	9a. FACILITY NAME (If not institution, give	street and number)											
8	FORT HOWA	RD HOSI	PITAL			FO	RT	HOWA	RD			n/	
DIRECTOR	RESIDENCE OF DECEDENT						-						
끮	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN (	OR LOCAT						1	Od. INSIDE CITY
	MARYLAND	n/a	1/a BALIIMURE 1 □X YES 2 □ NO										
MA.	10e. STREET AND NUMBER	101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY?											
FUNERAL		T	TREET				2	1201			UN	ITED	STATES
5	11. MARITAL STATUS	12. WAS DECEOEN FORCES? 1	T EVER IN U.S. A Y YES 2 C MAR OR DATES	RMED NO	13.	WAS DECI	ENDENT O	F HISPAN	IIC ORIGIN?	(Specify Yea	or No-	14. RACE Black, V	- American Indian, White, alc.
8	3 Widowed 4 Divorced		AR'OR DATES	- 4/		1 YES						Specify:	
	15. OECEOENT'S EQU	CATION		ECEOENT'S	USUAL O	CCUPATIO	in.	_	105.0	KINO OF BUS	INCOS (INC	NICTON .	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		Give kind of the Do NOT us	work done	during mos	st of workin	g	100.1	AINO OF BUS	INESS/INC	USINI	
교	12 TH	College (1-4 or 5	''	LAB0	RER					VAR	IOUS	TR	ADES
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	HER'S NAI	ME (First, Mi	ddle, Maiden	Sumame)		
ш	JOHN LINDS	SAY							ERTA	WALL			
00	19a. INFORMANT'S NAME (Type/Print)	LINDSAY	1	9b. MAILING	ADORESS	S (Street ar	nd Number	or Rural R	Route Numbe	r, City or Town	. Stete. Zio	Code)	
2	JOHN L.	LINSEY		311	C	ATHE	DRAL	ST	REET,	BALT	IMOR	E, MD	21202
	20e. METHOD OF DISPOSITION 1 X Ouriel 2 Cremetion 3 Rem			ANOOATE			me of		DATE	20c. LO	CATION —	City or Town	ı, State
	4 Donation 5 Other (Specify)	IOVAL FROM State	- GAR	RISON	ther place)	REST	V A	C EM	6-2	24 0	WING	S MIL	LS,MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	. /	1	22.	NAME AN	O AODRES	SS OF FAC	CILITY				
	J. Valen	ua Bli	Hla.	rd						FH1			ORTH AVE.
	23. PART I. Enter the diseeses, pr shock, pr heart failure.	complications the List only one cau	t coused tha d ise on each lin	leath. Do r ie.	not enter	the mod	da of dyi	ng, auch	n aa cerdii	ac or respi	ratory arr	eat,	Approximate Interval Between
	iMMEDIATE CAUSE (Finel disease or condition												Onset and Death
	resulting in death)	. RENAL											MONTHS
			(OR AS A CONSI	EOUENCE OF	F):								1005
CERTIFICATION	Sequentielly list conditions,	AIDS OUE TO	(OR AS A CONSE	FOLIENCE OF									1985
AT	if any, leading to immediate cause. Enter UNDERLYING		G AND A			רוואיזרוי	יייי איי						
임	CAUSE (Disease or Injury thet initiated eventa		(OR AS A CONSE			PEND	ENCI						-
E	resulting in death) LAST				,								İ
빙		0.											
A	PART ii. Other aignificant condition	e contributing to	death but not	reauiting	n the un	nderlying	ceuse g	jiven in l	Part I.	24a. WAS AN			ERE AUTOPSY FINDINGS
MEDICAL	CACHEXIA								_	1 XYES 2		C	OMPLETION OF CAUSE F GEATH?
N N	HISTORY OF SYPHII								_				YES 2 1 NO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN	1 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	OTHER								
YSI	1 YES 2 XNO	HOSPITAL:			4 🗆 Nun		5 🗆 Re	sidence (	6 🗆 Other (	Specify)			
표	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF (Month, D		28b. TIM	E OF URY	28c. INJU WOR	RK7		28d. OESC	RIBE HOW IN	JURY OCC	UREO	
m l	2 Accident Investigation				M		ES 2 _	NO					
유	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY AI h etc. (Specify)	ome, larm, s	street, lect	ory, office		- 1	281. LOCAT City or	Town, State)	nd Number	or Rural Rou	te Number,
	29a. CERTIFIER			_									
COMPLET	(Check only												
8	2 MEOICAL EXAMINE	R: On the beals of at	camination and/or	Investigatio	n, In my o	pinion, de	ath occur	ed at the I	lime, data a	nd placa, and	dua lo lh	e cause(a) a	nd manner as stated.
11	296. SIGNATURE AND TITLE OF CERTIFIE	R	- /				29c. LICE	NSE NUM	BER		204 DATE	SIGNEO (14	Ionth Dev Year)

29c. LICENSE NUMBER

O. M.D. 9600 N. POINT ROAD FORT HOWARD, MD
32. REGISTRAR'S SIGNATURE

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31. DATE FILEO (MOPPY, Day Year)

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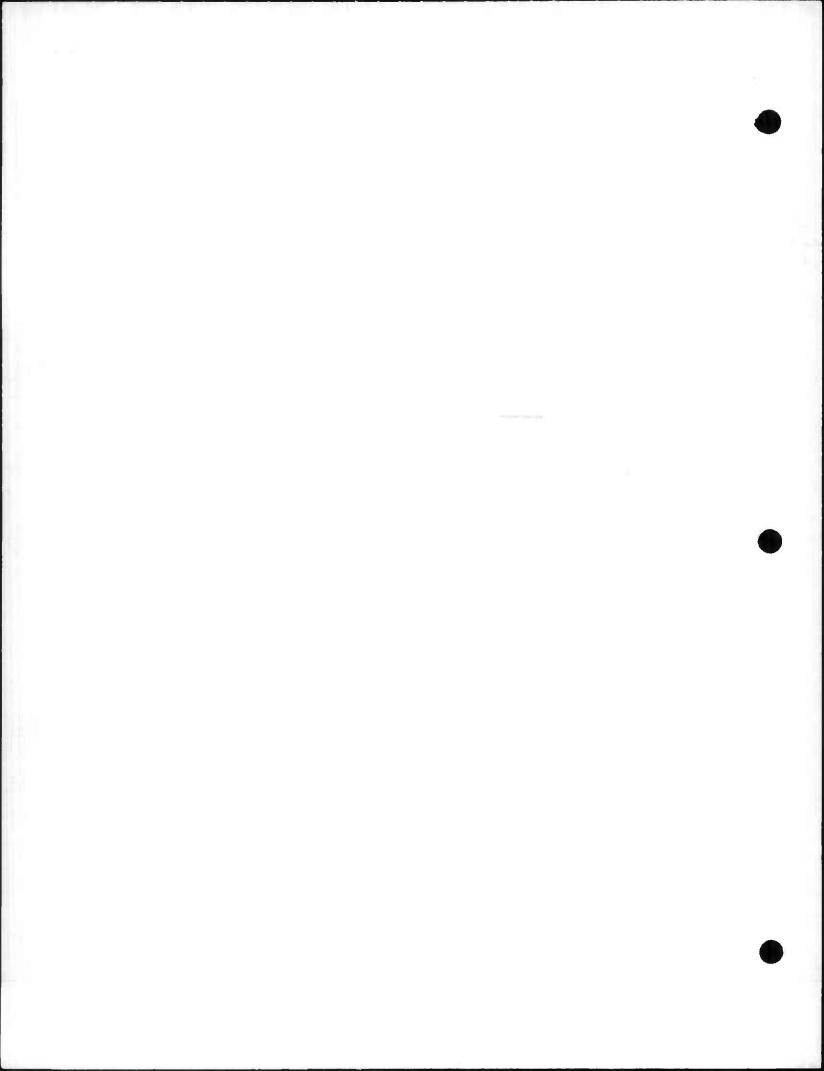
CUSTODIO,

1995

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29d. DATE SIGNEO (Month, Day. Year)

▶ JUNE18,195

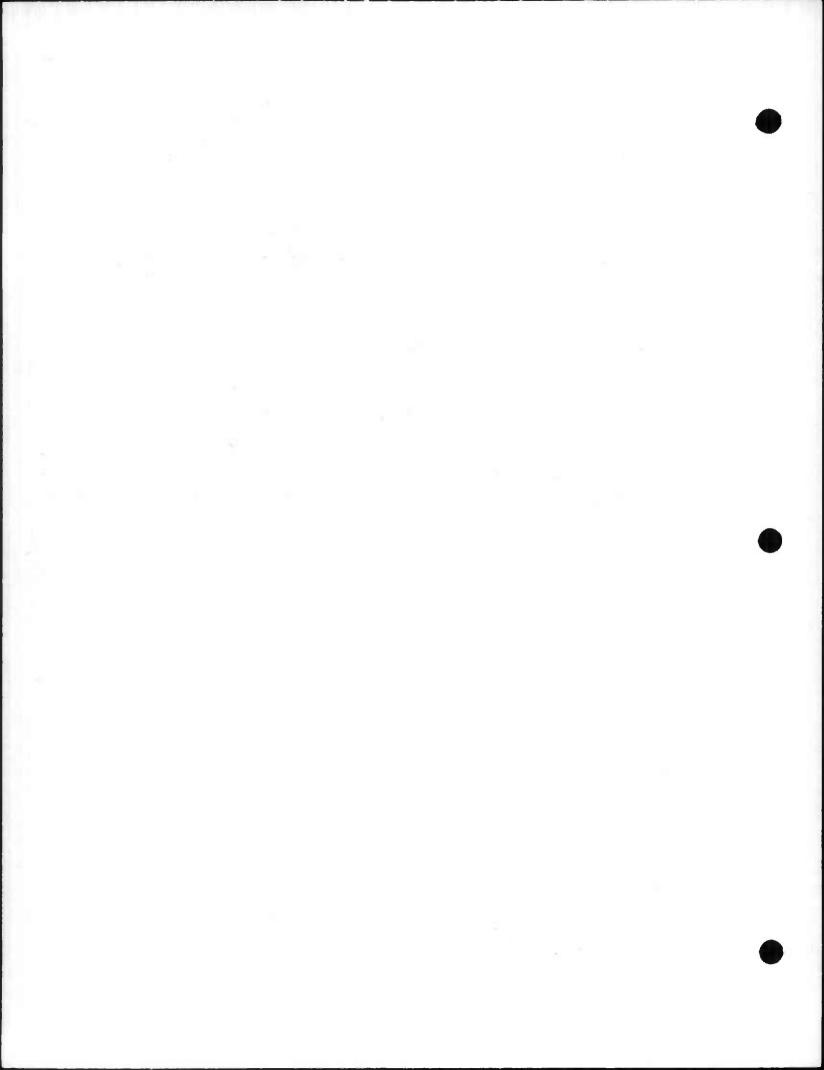


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3.7 hours after death. Prop. 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the first and after the certificate has been signed by the attending physician and completely filled in the first beginning the size Dept. of Health and Mental Hydiene prior to burial, cremation, at removal.  INPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at one.
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					95	8//9				
	1 - FOR STATE OF MARY		MENT OF HEALTH AND							
	1. DECEDENT'S NAME (First, Middle, Last)	9=11.1.	OAIL OF DEATH.	2. DATE OF DEATH		3. TIME OF DEATH				
	KITA I. LANDON			SUNE	0, 1995	1035 Am				
		GE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 01 20	8. BIRTHPI Country)	LACE (State or Foreign				
	203-05-9502 1 M ZZ F  9a. FACILITY NAME (II not institution, give street and number)	75 YRS.	2) 0274 2017 2017			SYLVANIA				
DIRECTOR	Sp. FACILITY NAME (IT NO Institution, give street and number)  NORTH ARUNDEL HOSPITAL  Sp. CITY, TOWN OR LOCATION OF DEATH  ARE ARUNT  RESIDENCE OF DECEDENT  Sc. COUNTY OF DEATH  ARE ARUNT  OF LEN BURNIE  MAR ARUNT  OF LEN BURNIE  SC. COUNTY OF DEATH  ARE ARUNT  OF LEN BURNIE									
R	10a. STATE 10b. COUNTY		TOWN OR LOCATION		1	IOd. INSIDE CITY				
	MARYLAND ANNE ARUNDEL		GLEN BURNIE		1	LIMITS?				
FUNERAL	100. STREET AND NUMBER 503 KINTOP ROAD		101. ZIP CODE 21.061		U.S.A					
	11. MARITAL STATUS 12. WAS DECEDENT EVE FORCES? 1 Y	ES 2 XNO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexico	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	s or No- 14. RACE - Black,	- American Indian, White, etc.				
D BY	3 Wildowed WXDivorced IF YES, GIVE WAR OF		1 ☐ YES 2 NO Specifi		WHI	TE				
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Che blad of un	SUAL OCCUPATION ork done during most of working retired.)	16b. KIND OF BU	SINESS/INOUSTRY					
APL	12 0	SWITCH	HBOARD PERATOR	STATIO	NARY SAL	ES				
COMPLETE	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	NAME (First, Middle, Malden Surname)						
BE	HARRY F. CLARK		MARY	C. DAL						
5	19s. INFORMANT'S NAME (Type/Print) ANN C. RINKER		JAY COURT-GLE			61				
1	20a. METHOD OF DISPOSITION LO Buriel 2 Cremetion 3 Removal from State	20b. PLACE AND DATE OF	Edisposition (Name of CEMETERY		CATION — City or Town					
	4 □ Donation 5 □ Other (Specify) □ 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE	CEDAR HI.	22. NAME AND ADDRESS OF FA		OOKLYN P	ARK, MD.				
	RAYMOND C. FINK FUNERAL HOME 2106.									
	23. PART I. Enter the diseases, or complications that cause or shock, or heart fallure. List only, one cause or	sed the death. Do no	t enter the mode of dying, auc	h aa cardiac or reap	iratory arreat,	Approximata interval Between				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ANCER			Onset and Death					
	resenting in death)	17 11 0	111000			1 7 CANK				
	DUE TO OR A	S A CONSEQUENCE OF)	EDINE		4	1 9 CANE				
NOI	Sequentially list conditions,	S A CONSEQUENCE OF):  S A CONSEQUENCE OF):	EDING			20945				
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	L BLE	EDING MBOPHLEBIDS	>		20A45 20A45				
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	L BLE	EDING MBOPHLEBIDS	>		20945 20A45				
SERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	L BLE s a consequence of: EIN THAO	EDING MBOPHLEGIDS	<b>S</b>		20945 20A45				
S	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	S A CONSEQUENCE OF:		Part I. 24s. WAS AN		2 DAYS 2 DAYS				
S	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	S A CONSEQUENCE OF:			RMED?	MAILABLE PRIOR TO COMPLETION OF CAUSE				
S	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions contributing to death	S A CONSEQUENCE OF):  A CONSEQUENCE OF):  The but not resulting in	the underlying cause given in	Part I. 24s. WAS AN PERFOI	AMED?	MAILABLE PRIOR TO				
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions contributing to death  DID TOBACCO USE CONTRIBUTE TO CAUSE	S A CONSEQUENCE OF):  A CONSEQUENCE OF):  A but not resulting in	the underlying cause given in	Part I. 24a. WAS AMPERFOI	AMED?	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERENCE TO MEDICAL EXAMINER?	S A CONSEQUENCE OF):  Thut not resulting in  OF DEATH YES  26. PLACE OF DEATH	the underlying cause given in	Part I. 24a. WAS AMPERFOI	AMED?	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE  25. WAS CASE REFERENCE TO MEDICAL EXAMINER?  1 YES 2 NO DIE TO (OR AND OUT TO (OR A	S A CONSEQUENCE OF):  The properties of the prop	the underlying cause given in  NO UNCERTAIL  (Check only one)  OTHER:  Nursing Home 5   Residence	Part I. 24a, WAS AN PERFOI  1 YES :	MO C	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE  25. WAS CASE RE ENTED DISEDICAL EXAMINER?  1 VES 2 NO LOSPITAL: 1 Inpartent 2 ER/O  27. MANNER OF DEATH  28e. DATE OF INJUR (Month, Day, Year	S A CONSEQUENCE OF):  The but not resulting in  OF DEATH YES  26. PLACE OF DEATH  Autpetlent 3 DOA 6	the underlying cause given in  NO UNCERTAIL (Check only one)  OTHER:  B   Nuning Home 5   Residence  OF   28c, INJURY AT	Part I. 24a. WAS AN PERFO	MO C	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE  25. WAS CASE REFERENCE OF MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  28. DATE OF INJUR (Month, Day, Yea.)  29. DATE OF INJUR (Month, Day, Yea.)  20. DATE OF INJUR (Month, Day, Yea.)	S A CONSCOUENCE OF):  The but not resulting in  OF DEATH YES  26. PLACE OF DEATH  Putpetient 3 DOA (1)  TY 28b. TIME (H)  URY — At home, ferm, str	the underlying cause given in    NO	Part I. 24a, WAS AN PERFOI 1 YES :	NJURY OCCUREO	MAILABLE PRIOR TO COMPLETION OF CAUSE FEATHY				
ED BY PHYSICIAN: MEDICAL CE	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other eignificant conditions contributing to death  DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE RE ERRED O MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH 1 Natural 5 Pending Investigation 1 Natural 5 Pending Investigation	S A CONSCOUENCE OF):  The but not resulting in  OF DEATH YES  26. PLACE OF DEATH  Putpetient 3 DOA (1)  TY 28b. TIME (H)  URY — At home, ferm, str	the underlying cause given in    NO	Part I. 24a. WAS AN PERFOI  1  YES :  5  Other (Specify)  28d. DESCRIBE HOW	NJURY OCCUREO	MAILABLE PRIOR TO COMPLETION OF CAUSE FEATHY YES 2 NO				
ETED BY PHYSICIAN: MEDICAL CE	DUE TO (OR A COUNTY IN TO CAUSE CONTRIBUTE TO CAUSE PART II. Other eignificant conditions contributing to death county in the co	S A CONSCOUENCE OF):  The but not resulting in  OF DEATH YES  26. PLACE OF DEATH  Putpetient 3 DOA (1)  TY 28b. TIME  HNJUI  IRY — At home, ferm, str  pecify)  OWledge, death occurred	the underlying cause given in  NO UNCERTAIL (Check only one)  OTHER: Nursing Home 5 Residence OF 28c. INJURY AT WORK?  I YES 2 NO  set, factory, office  at the time, data and place, end due	Part I. 24a. WAS AN PERFOIL  1 YES :  5 Other (Specify)  28d. DESCRIBE HOW City or Yown, State)  to the cause(s) end main	NJURY OCCUREO  and Number or Rural Rou	MAILABLE PRIOR TO COMPLETION OF CAUSE FEATHY YES 2 NO				
COMPLETED BY PHYSICIAN: MEDICAL CE	DUE TO (OR A CLASS CONTRIBUTE TO CAUSE CONTRIBUTE CONTRIBUTE TO CAUSE CONTRIBUTE CONTRIBUTE TO CAUSE CONTRIBUTE CONT	S A CONSCOUENCE OF):  The but not resulting in  OF DEATH YES  26. PLACE OF DEATH  Putpetient 3 DOA (1)  TY 28b. TIME  HNJUI  IRY — At home, ferm, str  pecify)  OWledge, death occurred	the underlying cause given in  NO UNCERTAIL (Check only one)  OTHER: Nursing Home 5 Residence OF 28c. INJURY AT WORK?  I YES 2 NO  set, factory, office  at the time, data and place, end due	Part I. 24a. WAS AN PERFOIL  1 YES :  5 Other (Specify)  28d. DESCRIBE HOW City or Yown, State)  to the cause(s) end main	NJURY OCCUREO  and Number or Rural Router as stated, and due to the cause(s) a	MALABLE PRIOR TO OMPLETION OF CAUSE FEATHY YES 2 NO				
BE COMPLETED BY PHYSICIAN: MEDICAL CE	DUE TO (OR A CLUB TO (OR A CLUB TO (OR A CLUB TO (OR ACLU	S A CONSEQUENCE OF:  CIVITY OF DEATH YES  26. PLACE OF DEATH OUTPUT  At home, ferm, str pocify)  At home, ferm, str pocify  CIRY AT home, ferm, str pocify  CIRY AT home, ferm, str pocify  CI	the underlying cause given in  NO UNCERTAIL  (Check only one)  OTHER:  8 Nursing Home 5 Residence  OF WORK?  1 YES 2 NO  seet, factory, office  at the time, data and place, end due In my opinion, death occured at the	Part I. 24a. WAS AN PERFOIL  1 YES :  5 Other (Specify)  28d. DESCRIBE HOW City or Yown, State)  to the cause(s) end main	NJURY OCCUREO  and Number or Rural Rou	MALABLE PRIOR TO OMPLETION OF CAUSE FEATHY YES 2 NO				
E COMPLETED BY PHYSICIAN: MEDICAL CE	DUE TO (OR A CLASS CONTRIBUTE TO CAUSE CONTRIBUTE CONTRIBUTE TO CAUSE CONTRIBUTE CONTRIBUTE TO CAUSE CONTRIBUTE CONT	S A CONSEQUENCE OF:  CIVITY OF DEATH YES  26. PLACE OF DEATH OUTPUT  At home, ferm, str pocify)  At home, ferm, str pocify  CIRY AT home, ferm, str pocify  CIRY AT home, ferm, str pocify  CI	the underlying cause given in  NO UNCERTAIL  (Check only one)  OTHER:  8 Nursing Home 5 Residence  OF WORK?  1 YES 2 NO  seet, factory, office  at the time, data and place, end due In my opinion, death occured at the	Part I. 24a. WAS AN PERFOIL  1 YES :  5 Other (Specify)  28d. DESCRIBE HOW City or Yown, State)  to the cause(s) end main	NJURY OCCUREO  and Number or Rural Router as stated, and due to the cause(s) a	MALABLE PRIOR TO OMPLETION OF CAUSE FEATHY YES 2 NO				



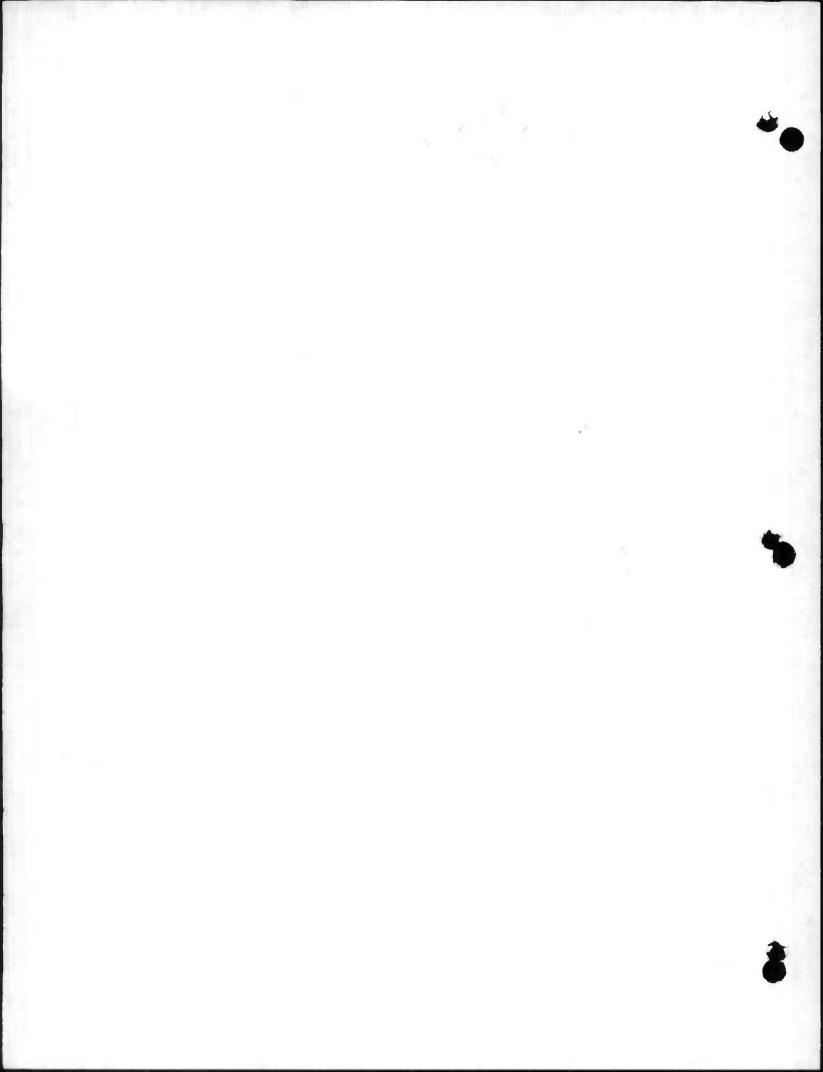
CERTIFICATE #

95-18780

SEE

CERTIFICATE #

95-20865



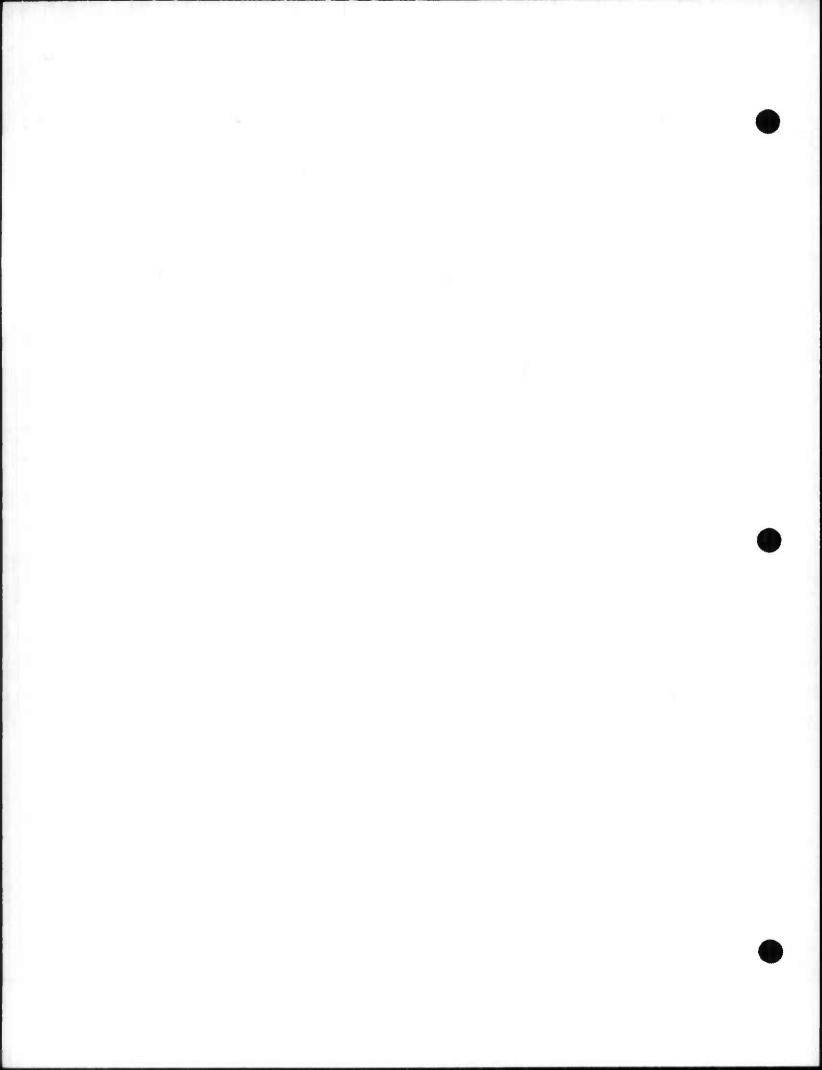
BALTIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	I THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh filed within 72 hours after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal.	a making avanatas must be splitted to see
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ified within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	DOCTANT if item 28 is marked or item 23 shaws any injury or other trainmatic event the medical examinar must be notified at some

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL HYGIEN REG. NO			
3	1. DECEDENT'S NAME (First, Middle, Last)	E Lenn	701			2. DATE OF DEATH	9 19	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 220-18-5020			F UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland	
NO.	9a. FACILITY NAME (If not institution, give s			b. CITY, TOWN C	OR LOCATION OF DE		9c. COUNTY		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		10c. CITY, 1	TOWN OR LOCAT	TION	- 4		10d. INSIDE CITY	
	Maryland	n/a	n/a Baltimore City					1 X YES 2 NO	
ERAI	3510 Hamilton Av	venue		101	1. ZIP CODE 212	14	10g. CITIZEI	USA	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR DO	2 X NO	13. WAS DEC	a or No — 14	RACE — American Indian, Black, White, etc.			
8	15. DECEOENT'S EDU (Specify only highest grade	16a, DECEDENT'S US (Give kind of work life, Do NOT use of	k done during mo	ON est of working	16b. KIND OF BU	SINESS/INOUS	White		
COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	Homem	memaker At					
	17. FATHER'S NAME (First, Middle, Lest)				ME (First, Middle, Malden				
BE	Edwin W. Monroe  19a. INFORMANT'S NAME (Type/Print)	3	19b. MAILING AG	DORESS (Street a		elyn Bud		rde)	
10	Mr. Albert P. Ler	non, Jr.			Avenue			yland 21214	
	20s. METHOD OF DISPOSITION  1 Burial 2 Cremetion 3 Ram		D. PLACE AND DATE OF metery, cremetory or other	r place)		1		y or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC	pary) /	Parkwood	22. NAME AN	NO A CORESS OF FAC	HLITY	<u>ltimor</u>	e Maryland	
	Michael	Lauck		5305 H	rd J. Ruc <u>Harford R</u>	oad Balt	imore	Maryland 2121	
	23. PART I. Enter the diseeses, of shock, or heart feilure.  IMMEDIATE CAUSE (Final diseese or condition resulting in death)	Elst only one ceuse on e	SEPS ( a consequence of):		oo or dying, add	a colored or resp	metory arrea	Approximata Interval Batwe Onset and Dei	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL CE	PART II. Other algorificent condition	contributing to deeth b			g cause given in I	Pert I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AN: N	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YES		UNCERTAIN	1 12		1 Tes 2 No	
□ □	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HÓSPITAL:	28. PLACE OF OEATH	(Check only one)					
HYS	1 TES 2 NO 27. MANNÉR OF CEATH	T☐ Inpatient 2 ☐ ER/Outp	28b. TIME C	OF 28c. INJ		B Other (Specify)  28d. OESCRIBE HOW I	INJURY OCCUP	NEO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR		YES 2 NO				
TED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, stre	et, factory, offic	•	28f. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,	
COMPLE	nne)	CIAN: To the best of my know						euse(s) and manner as stated.	
ш	296. SIGNATURE AND TITLE OF CERTIFIE	1	10		29c. LICENSE NUM	BER	29d. DATE S	IGNED (Month, Day, Year)	
TO B	30. NAME AND ADDRESS OF PERSON WH	Nan	MI)		AC 523	31535	▶ 06	119/95	
	PATRICIA AYR	ES 20	1 E UNI	1 Pul	UAT, 3	A STIMOR	St		
10	JUN 2 1 1995	32. REGISTRAR'S SIGN	LL						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the form. Page 6 may be retained by the hospital or attending physician.

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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S HAME (First, Middle, Last) HALLIE LEWLS			2. DATE OF DEATH MONTH DAY TUNE	3. TIME OF DEATH						
	4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign								
	216-14-1189   1 □ M 2 🕃 ₹ 72	2 YRS. MON	THE DAYS HOURS MIN.	(Month, Day, Year) Feb. 14.10	923West Virginia						
	Se. FACILITY HAME (If not institution, give street end number)	9b.	CITY, TOWN OR LOCATION OF		C. COUNTY OF DEATH						
DIRECTOR	Caton Manor 3330 Wilkens	N/A									
H	10a, STATE 10b, COUNTY	100	WN OR LOCATION		10d. IHSIDE CITY LIMITS?						
	Maryland N/A	Balt	imore		1 XYES 2 NO						
FUNERAL	10e. STREET AND HUMBER		10f. ZIP CODE		8g. CITIZEN OF WHAT COUHTRY?						
NE	200 1st Avenue		21227		United States						
BY FU	11. MARITAL STATUS  1 Never Merried 2 Merried  3 💢 Widowed 4 Divorced	2 X NO	13. WAS DECEMBENT OF HISP/ If yes, specify Cuben, Mexic  1 YES 2 XNO Specify Cuben	en, Puerlo Ricen, atc.)	Black, White, etc. Specify:						
Q	15. DECEDENT'S EDUCATION	16e. DECEDENT'S USU	AL OCCUPATION	16b. KIND OF BUSINE	White						
ET	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of work of life. Do NOT use reti	done during most of working	TOD. KIND OF BUSINE	.aa/mbosiny						
1PL	8	homema	ker	own h	ome						
COMPLETED	17. FATHER'S HAME (First, Middle, Last)		16. MOTHER'S H	AME (First, Middle, Malden Sun							
BE C	Layton W. Phares		Ethel	Crickerd							
TO B	19e. IHFORMANT'S HAME (Type/Print)	19b. MAILINO ADD	RESS (Street and Number or Rura		Itefs, Zip Code)						
ĭ	Pamela Jackson	201 2n	d Avenue La	nsdowne, Ma	ryland 21227						
	1 L∆Buriel 2 ☐ Cremation 3 ☐ Removal from State   Com	PLACE AND DATE OF DIS	SPOSITIOH (Nama of	DATE 20c. LOCAT	ION — City or Town, State						
- 1	21. SIGNATURE OF FUNERAL BERVICE LICENSEE	TATALIG A	22. HAME AND ADDRESS OF F	ACILITY	ison Forest,Md.						
	and the	-6			of Lansdowne						
	22 0447   5-11-11	٠.	2719 Hammon	ds Ferry R	oad 21227						
	23. BART I. Enter the diseases, or compilestions that caused shock, or heart fellure. List only one cause on each	l tha daath. Do not a sch line.	nter the moda of dying, su	ch se cerdiac or respirato	ory srreat, Approximate Interval Between						
1	Onset and Death										
	disease or condition a. ACVTE	T NIOhrs									
_	DUE TO (OR AS A CONSEQUENCE OF):  ATUEROSCE FROSIS										
CERTIFICATION	Sequentially list conditions,  Due TO (OR AS A CONSEQUENCE OF):										
M	cause. Enter UNDERLYING	NG .									
Ē	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A	CONSEQUENCE OF):									
	resulting in desth) LAST										
	PART II. Other significant conditions contributing to deeth be										
4	Multi Infarct Demer	ot not reauting in th	e underlying causa given ir	Part I. 24e. WAS AN AUT PERFORMED	D? AVAILABLE PRIOR TO						
MEDIC		25		1 TYES 2 TX	NO COMPLETION OF CAUSE OF DEATH?						
		Disease			1 TES 2 HO						
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE O			N 🗆 📗							
O	EXAMINER? HOSPITAL:	26. PLACE OF DEATH (C/	HER:								
14S	1   YES 2   NO   1   Inpatient 2   ER/Outp.  27. MAHNER OF DEATH   28s. DATE OF INJURY		Nursing Home 5 - Residence								
	1 Netural 5 Pending	26b. TIME OF INJURY	28c, INJURY AT WORK?	26d. DESCRIBE HOW INJUI	AY OCCURED						
BY	2 Accident Investigation 28e PLACE OF IN HIRV	- At home, ferm, street,	M 1 YES 2 NO								
COMPLETED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY building, atc. (Special Country of the country of the	ify)	, isotory, office	City or Town, State)	Number or Rural Route Number,						
2	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beet of my knowledge)	edge, death occurred at	the time, date end place, end du	e to the cause(e) and menner	se stated.						
S .	one) 2 MEDICAL EXAMINER: On the beele of exemination										
BE C	296. SIGNATURE AND TITLE OF CERTIFIER		29c, LICENSE HU		D. DATE SIGNED (Month, Day, Year)  TUNE 19, 1995						
2	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Print)	Ton Ad	Bull, MI							
			Ferry Rd,	round INIT	1 alda /						
	31. DATE PLED (Month 1995) Julia Office Repistra Signi	<b>Z</b> PRE									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

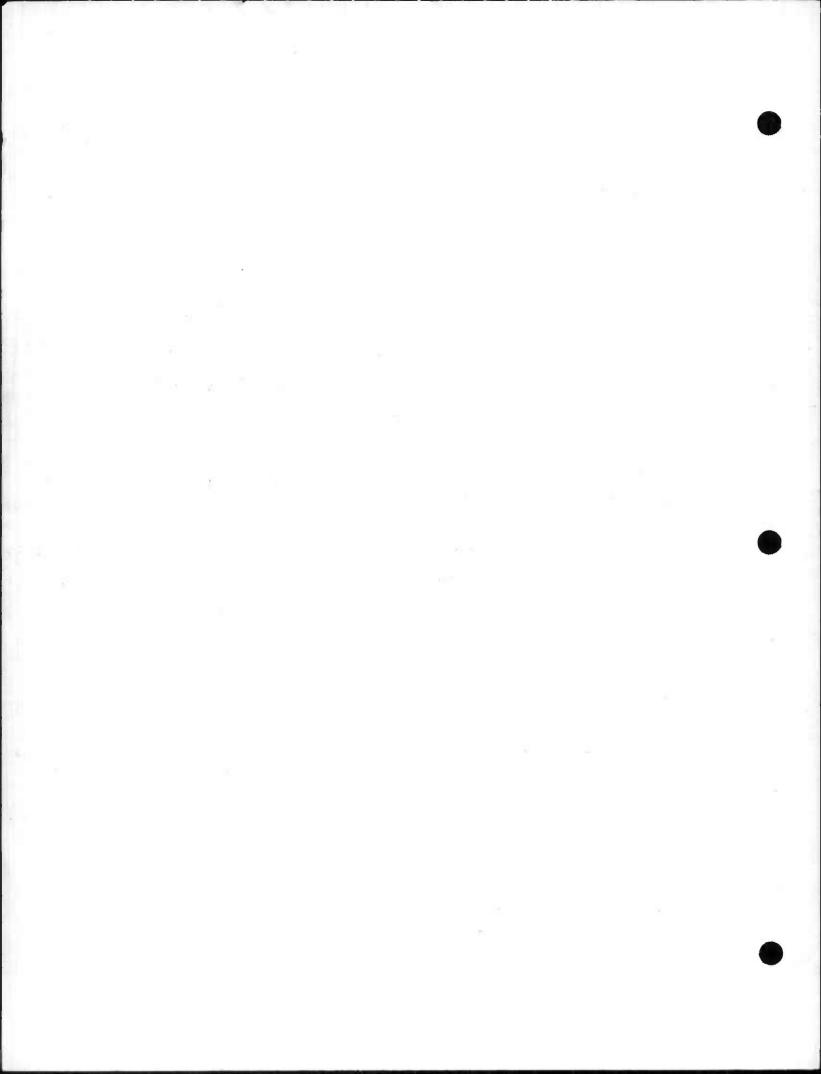
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
OECEDENT'S NAME (First, Middle, Last)		A DATE OF OFATAL

	1. OECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATH														
	Ruth	ALMET	Α			M: 1	ler			MONTH	DA	**	YEAR		
	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER	1 24 HRS.	7. DATE 0	e 19	19			P M
	242-05-2073	3	1 - M 2 - XX	89	YRS.	MONTHS	DAYS	HOURS	MIN.	91970	10,19	906	Sountr S.	AR	OLINA
	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN						OLIWA		
E C	Maryland General Hospital							more					n/a		
5				pricar					=			<u> </u>			
DIRECTOR	MARYLAND	10b. COUNTY			10c. CIT	Y, TOWN								10d. INSI	DE CITY
			n/a			B <i>F</i>	LTI								2 NO
RAI	100. STREET AND NUMBER 1631 N.	MOLE	E STREE	ener			101	. ZIP COD	_			1.0		VHAT COU	
FUNERAL		WULF							.213				TED	STA	IF2
5	11. MARITAL STATUS  1 Never Married 2	Married	FORCES? 1		MED (O	1	If yes, so	ecify Cuba	rs. Mexica	IIC ORIGIN? n, Puerto Ri	(Specify Yes	or No-	14. RACE Black	- Americ White, et	can Indian,
BY	3 XXWidowed 4 Dive		IF YES, GIVE V	AR OR OATES			1 TYES	2 (1)	Specify	e			Speci	hy: BI	ACK
		EOENT'S EDUC		18a. DE	CEOENT'S	USUAL O	CCUPATIO	ON		16b. I	(IND OF BUS	SINESS/INC	DUSTRY	-	
COMPLETED	(Specify onli Elementary/Secondary (C	y highest grade	College (1-4 or 5		ive kind of a Do NOT us	work done se retired.)	during mo	st of working	ng	7,525					
릴	12 TH			"	DOM	1ESTI	C				outsid	de of	ho	me	
Š	17. FATHER'S NAME (First, M										ddle, Meiden	Surname)			
BE	HANNIBA	L JA	MES					0	CTAV	IA N	1C FA	ADDEN			
9	19a. INFORMANT'S NAME (			191	. MAILING	AOORES					r, City or Town			-	
F	JAMES	MILLER			163	31 1	1. V	VOLFE	ST	REET,	BALT	IMOR	E,MD	212	13
	20a. METHOD OF DISPOSIT  1 XIX Burlel 2 □ Crematic		oval from State	20b. PLACE	ND DATE	OF OISPOS	SITION (Na			OATE	20c. LO	CATION -	City or To	wn, Stata	
	4 Donallon 6 Other			CE DA	KR" F			1ETER		23	ANN	IE A	RUND	EL C	0., MD
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	1 0	1			O ADDRE			101	- N	ODTU	0.14	
	5.00	den	ua o	Wells	TUX	, w	(I <sup>V</sup> I • (	, IMP	KCH	rn1	.101	L. N	UKIH	AV	ENUE
	23. PART I. Enter the d	seasea, or c	omplications the	t ceused the de	ath. Do r	not enter	the mo	de of dy	ing, auch	n aa cardii	c or reapi	ratory an	reat,		proximate
	ahock, or heert fellure. List only one ceuse on each line.  Interval Between IMMEDIATE CAUSE (Final  Onset and Death														
	disease or condition										im	mediat			
	OUE TO (OR AS A CONSEQUENCE OF):											uiica Lat			
Z	Sequentially list conditions, Aspiration immedia:											mediat			
CERTIFICATION	If any, leading to immediate														
5	CAUSE (Disease or Injury														
Ē	that initiated events resulting in death) LAS	т	OUE TO (OR AS A CONSEQUENCE OF):												
핑	d														
A	PART II. Other algnifice	nt condition	s contributing to	deeth but not r	eaulting	In the ur	derlyln	Ceuse (	given in i	Part I. 2	4a. WAS AN PERFOR		24b.		OPSY FINDINGS
MEDICAL									_	YES 2				ON OF CAUSE	
E											-				2 NO
	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 I	NO [	UNC	ERTAIN	10					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	28. PLAC	E OF OEAT	OTHER									
YSI	1 TES 2 TYNO		Typetient 2		□ DOA			• 5 □ Ra	sidence	6 🗆 Other (	Specify)				
H H	27. MANNER OF OEATH  1 Notural 5	Pending	28a. DATE OF (Month, D		28b. TIM INJ	E OF IURY	28c, INJ WO	URY AT RK?		28d. OESC	RIBE NOW II	NJURY OC	CUREO		
BY		investigation				М		'ES 2 [	NO						
ED		Could not be determined	28e. PLACE O building,	F INJURY — At ho atc. (Specify)	me, ferm, :	street, fact	ory, office	•			TON (Street a Town, State)	nd Number	or Rural R	oute Numb	BC,
Ē.															
AP.			CIAN: To the best of												
COMPLET	2   MEOI		R: On the besis of a	amination and/or i	rrveatigatio	n, In my o	pinlon, d	eath occur	ed at the	time, data a	nd place, and	d due to th	e cause(s)	and menr	or as stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	2						NSE NUM					(Month, De	
2	1 hol	1 '0'	. Or	~ m				8	9203	3		▶ Ji	une	19,	1995
- 1	36. NAME AND ADDRESS OF	PERSON WHO	MT)	DE OF OEATH (ITE	27) (Type,	Print)		7 **		. 4	00=				
	Justin H	yrne,	TID C/	J Mary	.and	Ger	nera	IT H	ospi	Ltal	827	Lin	den	Ave	•
	31. DATE FILED QUOUP. 99	95 Ju	20 25 64 124	S. EIGHOTHE											
		U													



1020

BALTIMORE, MARYLA

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be making by min TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 amount he defined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

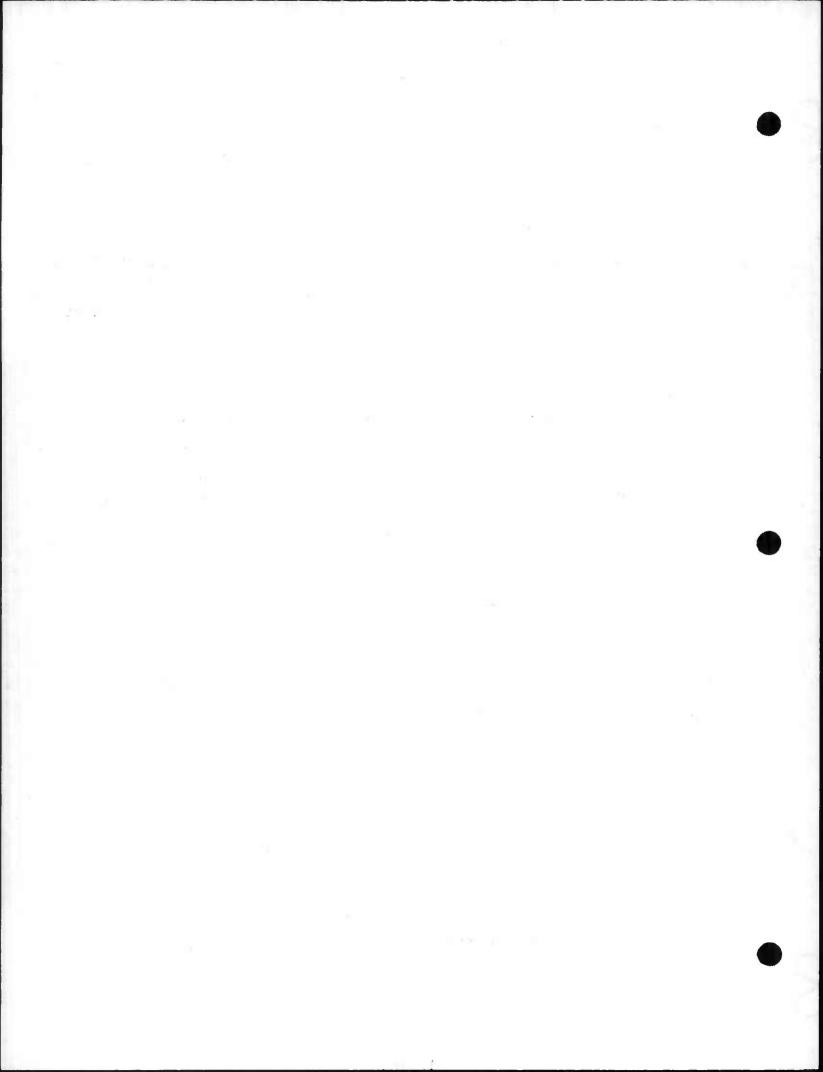
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DIVISION OF VITAL RECORDS, P.O. BOX 68769

	FOR	T Pol		/ DEDAG	THEFAI		F 4 1 7 1 1	AND			_		
	1 - STATE REGISTRAR	SIMIE UF I	MARYLAND C	ERTIF					MENI	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)  NEIC Neill M	URPHY								NE I	<b>6</b> , 1	995	3. TIME OF DEATH 12:15 P
	4. SOCIAL SECURITY NUMBER	st birthday)	IF UNDER	DAYS	IF UNDER		7. DAT	E OF BIRTN Wh, Day, Year)	T	8. BIRTH	PLACE (State or Foreign		
	237-28-5593  9e. FACILITY NAME (# not institution, give s	84	YAS.				MIR.	Apr	24 19	11	Nort	th Carolina	
DR	18 NORTH MORLE				MORE				9c. COUN		EATN		
5	RESIDENCE OF DECEDENT			_				. 01				N/A	
DIRECTOR					Y, TOWN								10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER	N/A			BALT		ZIP COD				10g. CITIZ	ZEN OF W	THAT COUNTRY?
FUNERAL	18 N. Morley Stre	et					21	229			1	1.5.4	4
FU	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDEN	TEVER IN U.S. AF	RMED NO						IN? (Specify Yes		14. RACE	- American Indian, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES				2 X NO			,		Specif	
PLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	ECEDENT'S	work done			ia .	16	b. KIND OF BU	SINESS/IND	USTRY	DLACK
J.E	Elementary/Secondary (0-12)	College (1-4 or 5	+)	. Do NOT u	e retired.)								
-	17. FATHER'S NAME (First, Middle, Last)		N	AITE	R		18 MOTI	JED'S NA	ME /Flort	UNKNO Middle, Meiden			
BECO	HENRY MURPHY									CULLON	our name y		
TO B	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street e	nd Number	or Rurel I	Route Nur	nber, City or Tow	n, State, Zip	Code)	
-	HAZEL MURPHY		1	8 N.	Mor	ley	Stre	et.		imore.	Mary	lanc	21229
	20e, METHOD OF DISPOSITION 1 W Burlei 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelary, cramatory or other place)  Complete Company or other place)												
	SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											Maryland	
(	WILLIAM C. BROWN COMMUNITY F/H												
	23. PART I. Enter the diseases, or o	complications the	t caused the de	eath. Do r	not enter	the mo	de of dy	ng, suc	h ae ca	rdiec or reepi	ratory arm	eet,	Approximate
	shock, or heart fallure. List only one ceuse on each line.  IMMEDIATE CAUSE (Finel									Onset and Death			
	disease or condition reaulting in death)		c Cardiovascular Disease										
_	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentielly ilst conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											1	
2	CAUSE (Disease or injury that intiliated events  DUE TO (OR AS A CONSEQUENCE OF):												
	that initiated events resulting in deeth) LAST	00 300	(OH AS A CONSE	OUENCE OF	F):								
B	2007 // 201	1											,
PR	PART ii. Other algnificant condition	a contributing to	death but not i	resulting	In the un	derlying	cause ç	jiven in	Part i.	PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
E							_			1 TYES 2	XNO		OF DEATH?
PHYSICIAN: MEDICA	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	S 🗆 1	NO [	UNC	ERTAIN	N D	INSPE	CTIO	1	1 YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEAT	OTHER	-							
14SI	XX YES 2 NO	1 Inpatient 2 28e. DATE OF		26b, TIM	4 🗆 Nun	sing Nom		eldenca		er (Specify)			
	XXNatural 5 Pending	(Month, D			URY M	28c. INJI WO		NO	26d. DE	SCRIBE NOW I	NJURY OCC	URED	
D BY	3 Suicide 8 Could not be	28e. PLACE O	F INJURY At he	ome, ferm, s	street, fect	ory, office			281. LOCATION (Street and Number or Rural Route Number,				oute Number,
	4 Nomicide determined building, etc. (Specify)  Gity or Town, Stete)												
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFYING PNYSH												end menner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month.)												
TO BE	Dennis !			29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)  O.C.M.E  JUNE 16, 199									
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	SE OF DEATH (ITE	M 27) /Tros	Delet)								
F	Dennis Chute M					tra	<b>.</b> +	Ral	++-	oro	W =	land	1 21201

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		1 - FOR REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIE		
	1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH		3. TIME OF OEATH
		Samuel M. Martir					June 19	199	5 1000 Tm
	1 %	010 05 5000	SEX B. AGE (	n yrs. last birthday) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		HRTHPLACE (State or Foreign country)
pino		9e. FACILITY NAME (If not institution, give street		/ This.	Oh CITY TOWN	OR LOCATION OF O	Sept.26	,1907 <sub>V</sub>	irginia
1, 2, 3 should	CTOR	N/A RESIDENCE OF DECEDENT			Arbut		CAIR		imore
Pages 1	REC	10a. STATE 10b. COUNTY		10c, C/1	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
₩ &	ā	Maryland Baltin	nore	Aı	butus				1 YES 2 NO
I permit.	FUNERAL	10e. STREET AND NUMBER			10	H. ZIP COOE			OF WHAT COUNTRY?
020 physician. burial-transit	N.	1226 Circle Driv				21227			ed States
020 physician, burial-trar		1 Never Merried 2 Neverled	. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 <b>2</b> (NO	If yes, sp	pecify Cuben, Mexico	NIC ORIGIN? (Specify an, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc.
P 2 4	ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR ON DA	1123	1 L YES	S 2 X NO Specif	ly:		specify: White
Se afte	E	15. DECEDENT'S EDUCATION (Specify only highest grade company)	ON pleted)	(Give kind of	USUAL OCCUPATION	ON ost of working	16b, KIND OF E	BUSINESS/INDUST	
ND 21 hospital or ached for u	LET	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	Flacts	se retired.) Cical e	nginer	11+3	lities	
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		FIECU	. I Cal e	-	AME (First, Middle, Meid		
# & &	U O	unknown				Emma N		en sumame)	
MAR retained 5 should notified	00	19e. INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (Street		Route Number, City or 1	own, State, Zip Cod	n)
5 5 5	임	Louise E. Marti	n	1226	Circle	Drive	Arbutus	,Maryla	and 21227
		20e. METHOO OF DISPOSITION  1X Burlal 2 Cremetion 3 Removal	from State 20b.	PLACE AND DATE	OF DISPOSITION (Na	ame of		LOCATION - City	
Page 6 m il director,		4 Donation 5 Other (Specify)	Lo	etery		ltimore	e,Maryland		
		() () 5	4	0			neral Ho	me	Arbutus
IS after de n by the fu removal.		150	3( >	-ung	1328	Sulphu	ar Sprin	g Road	21227
		23. PABP I. Enter the diseasea, or companies, or heart fallure. List	plications that caused only one cause on ea	the death. Do i ich line.	not enter the mo	ode of dying, suc	ch ea cardiec or rea	piratory arrest,	Approximata Interval Between
F 9 m		IMMEDIATE CAUSE (Finel disease or condition	Multi	d. A	1 la	4. 7			Onset and Death
ted within the completely fille (al., cremation, event, the		reaulting in death) a		CONSEQUENCE O		74			3,5 yrs.
executed and con o burial, natic e	z	Convertibility New years that we do b.							
	CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	(OR AS A CONSEQUENCE OF):					
ortificate be ng physician giene prior t	II	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				
· 0 5 2 =	ERTIFIC	resulting in death) LAST			,				į
		PART II. Other aignificant conditions co	entributing to death by	th most requilities	le the made dute		201 100 000		
- > 5 -	CAL	The state of the s	onthibuting to death be	at not readiting	in the underlyin	g ceuae given in	PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
S teg in	IEDIC/						1 YES	2 NO	OF DEATH?
St. of see	N: M	DID TOBACCO USE CONTRIBU	UTE TO CAUSE O	F DEATH YE	S NO [	UNCERTAI	N D	SW	1 YES 2 NO
4 9 E C E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)				
	YSI	1 U YES 2 NO	Inpatient 2 ER/Outpo	ntient 3 🗆 DDA	OTHER: 4  Nursing Horn	ne 5 Residence	6 Other (Specify)		
PHYSICIAN: this certifica with the St	РНУ	27. MANNER OF DEATH Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	PRK?	26d. DEŞCRIBE HOV	INJURY OCCURE	D
	ВУ	Accident Investigation	28e. PLACE OF INJURY	— At home, farm		YES 2 NO	28f. LOCATION (Stree	at and Mumber on Ch	- Communication
TTEN TOR:	ETED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci	fy)	and at, rectory, office		City or Town, Sta	te)	rai Houte Number,
AL OR A AL DIREC 72 hours 11 item	PLE	29e. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowle	edge, death occum	ed at the time, date	end place, end due	to the cause(s) end m	nanner as stated.	
	COMPL	MEDICAL EXAMINER: OF	n the basis of exemination	end/or investigation	n, in my opinion, d	leath occured at the	time, date end pisce,	end dus to the ceu	se(s) end manner es stated.
THE HOSPI THE FUNEF filed within	BE (	296. SIGNATURE AND TITLE OF CERTIFIED	1.60	14		29c. LICENSE NUI	WBER	29d. DATE SIG	NED (Menth, Day, Year)
6 5 8 W	OT.	30. NAME AND ADDRESS OF PERSON WHO CO	MAD STED CALLET OF ST	Y atemas =	Drivet.	024	556	6/	20/55
		Un C WATERFIE	St.	Agres ly	1 1	900	Cato fe	7 212	
		31. DATE FILEO (Month, Day, Year)	32 REGISTRAR'S SIGNA		-1100	10		010	7
		JUN 2 1 1995 Juli	divdentant	all					



Pages 1, 2, 3 should

permit.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-tran
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

31. DATE FILEO (Month, Day, Year)

JUN 2 1 1995

34 REGISTRAR GIGNATURE

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Norfleet George 95 10:22 6 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morth, Day, Year) NOV.9,1944 IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 212 44 0860 1 M 2 | F 50 MONTHS DAYS HOURS YRS. MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9h. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNIVERSITY OF MARYLAND HOSPITA BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/ABALTIMORE YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 3016 ASCENSION STREET 21225 S OF 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cubin, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Sector 12TH condary (0-12) College (1-4 or 5+) LABORER FACTORY 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnal notified at BE GARFIELD NORFLEET BLANCHE PAIGE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 REV 3016 ASCENSION STREET DENISE NORFLEET BALTO., MD. 21225 e 20 METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must LOUNDON PARK CEMETERY 4 Donation 5 Other (Specify) 6/22 195 balto..md 21. SIGNATURE OF FUMERAL SERVICE LICENSEE examiner Lewis Service LICENSEE T. 22. NAME AND ADDRESS OF FACILITY
LEWIS T. GWYNN FUNERAL HOME GWYNN 21215 4517 PARK HEIGHTS AVE. BALTO., MD. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death the disease or condition DUE TO (OR AS A CONSEQUENCE OF): ine week resulting in death) event, End stage Real DUE TO (OR AS ADDINSEQUENCE OF): discase traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury failure Heart other OUE TO (DR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE any 1 TYES 2 TLAND OF DEATH? 1 TES 2 10 116 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: g 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATN (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) TIME OF 26c. INJURY AT 26b. 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending M 1 YES 2 ND BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 99 COMPLETED 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE THO TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Montp. Day, Year) 65 La 25 9 WHD COMPLETEO CAUSE DF OEATN (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF FERSON 22. S. Greene

tend I have been set  BALTIMORE, MARYLAND

permit. Pages 1, 2, 3 should

24 hours after death. Page 6 may be retained by the ho TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be intained by the high PHERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the functal director, page 5 attends be dead be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be nettilised at and

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

PATRICK OKOLO III, M.D. DEPT. O

31. DATE FILED (MONTH DEV. 2 1 1995)

32. PROSETRATE SIGNATURE READER

JUN 2 1 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Item1,g-724,6-21-9	5,perf.h.,dk						9	J	0101	
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / D CEF	EPARTMEN RTIFICAT	IT OF H	EALTH AND	MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF DEAT		T	). TIME OF DEATH	
	WILLIAM D.	OTRADOV.		JUNE 18TH 1995 238 P							
	4. SOCIAL SECURITY NUMBER		(In yrs. lest bi	foth days are swam	ER 1 YEAR					G - M	
	The second of th	V		MONTH		HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea	r)	Country)		
	215-28-6824		52	YRS.			June 26,	1932	Mar	yland	
	Sa. FACILITY NAME (If not institution, give s			9b. Cl	TY, TOWN	OR LOCATION OF D	EATH	9c. CO	UNTY OF DEA	тн	
OR	Franklin Square	. Hospital			Bal	Etimore		Ralt	imore	County	
5	RESIDENCE OF DECEDENT							радо	THOTE	Country	
DIRECTOR	10a. STATE 10b. COUNTY	1	1	10c. CITY, TOWN	OR LOCA	TION			1	od. INSIDE CITY	
	Maryland B	altimore		Ва	ltimo	170			- 1	LIMITS?	
7	10s. STREET AND NUMBER					. ZIP CODE		10g. CI		AT COUNTRY?	
£	1522 Weyburn Roa	d				21237			. S. A		
ž	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN 11 0 A DATE						_		
7	1 Never Married 2 X Married	FORCES? 1 YES	2 NO	13	If yes, sp	ENDENT OF HISPA ecify Cuban, Mexic	NIC ORIGIN? (Specifian, Puerto Rican, etc.	Yea or No-	14. RACE - Black, 1	- American Indian, White, atc.	
斋	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I			1 TYES	2 NO Speci	lly:		Specify:	White	
D	15. DECEDENT'S EDUC	Korear							1	wille	
#	(Specify only highest grade	completed)	(Give	DENT'S USUAL kind of work don	e during mo	ON ist of working	16b. KIND OF	BUSINESS/IF	NDUSTRY		
2	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired	*						
進	12th Grade		Мас	hine o	perai			TT			
COMPLETED BY FUNERAL	T. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, Ma	iden Surname)	_		
BE	William Otradov	ec				Marga	ret Horn	ey			
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Tow										
P Audra M. Otradovec 1522 Weyburn Road, Baltimore, Maryland								uland	21237		
	20s, METHOD OF DISPOSITION	20		DATE OF DISPO					- City or Town		
	1 X Buriel 2 Cremation 3 Remo										
1   Burial 2   Cremation 3   Removal from State   Cappetery, gramatory or other place   4   Donation 5   Other (Specify)   GATALENS OF FAITH   6 / 22/95 Baltimon 21. BURNATURE OF FUNERAL SERVICE LICENSEE   22. NAME AND ADDRESS OF FACILITY								nore. 1	Maryland		
Ш	The state of the s	111		2	Schi	munek Fi	ineral Ho	mo			
Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 1									21213		
	23. PART I, Enter the disesses, or o	complications that cause	d the death	n. Do not ente	er the mo	de of dving sur	h sa cardisc or n	anireton, a	read .	Approximate	
	Interval Batween										
	iMMEDIATE CAUSE (Final disease or condition									Onset and Death	
	resulting in death)	<u>Dilated Ca</u>	rdiomy	yopathy	y					7 years	
		DUE TO (OR AS	A CONSEQUE	ENCE OF):							
Z	Sequentially list conditions,	b									
Ĕ	if any, leading to immediate	DUE TO (OR AS	A CONSEQUE	ENCE OF):							
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	2.									
CERTIFICATION	that initiated events	DUE TO (OR AS	A CONSEQUE	ENCE OF):							
	resulting in death) LAST	c.									
2											
4	PART II. Other aignificant condition		but not resu	ulting in the u	ınderiyin	g ceuse given in	Part I. 24a, WAS	AN AUTOPSY		ERE AUTOPSY FINDINGS	
용	Chronic Renal Ir	sufficiency						5 2 X NO	C	OMPLETION OF CAUSE	
ΨĪ	Rheumatoid Arthr	itis						- 42.4		F DEATH?	
-	DID TOBACCO USE CONTR		DE DEATH	YES 🗆	NO IX	UNCERTAI	N D		- 1	L TES 2 NO	
₹	25. WAS CASE REFERRED TO MEDICAL	MOTE TO CHOSE C		OF DEATH (Chec		DINCERIA					
PHYSICIAN: MEDICAL	EXAMINER?  1 TYES 2 X NO	HOSPITAL:		OTHE	R:						
≥	27. MANNER OF DEATH	1 1 Inpatient 2 ER/Out					8 Other (Specify)				
픕		28a. DATE OF INJURY (Month, Day, Year)	2	8b. TIME OF INJURY	28c. INJ WO	URY AT RK?	28d. DESCRIBE HO	W INJURY O	CCUREO		
B	1 Natural 5 Pending 2 Accident Investigation			M		/ES 2 NO					
	3 Suicide 5 Could not be	28a. PLACE OF INJURY building, atc. (Spe	Y — At home,	farm, atreet, fa	ctory, offic		28f. LOCATION (Str City or Yown, S	eet and Numbe	er or Rural Rou	te Number,	
	4 Homicide detarmined						J., G. 10#/1, G				
COMPLETED	29a. CERTIFIER 1 X CERTIFYING PHYSIC	CIAN: To the best of my know	wledge death	occurred at the	time day-	and place and a	to the monetal and		elori.		
ž		R: On the basis of axamination									
8			ELIGIOT HIVE	ouganon, in my	ориноп, о	water occured at the	mme, data and place	, and due to t	me cause(s) a	nd manner as stated.	
BE	296. 9 GN ATUHE AND VITLE ON CERTIFIER					29c. LICENSE NUI	MBER			Ionth, Day, Year)	
	1/1/20/01	me mo				D46.	33 4	<b>D</b>	THUE !	1874 1993	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (See Print)											

OF MEDICINE, FRANKLIN SQ. HOSP. BAL

completely filled In rial, cremation, or I

permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely if fled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, crematic
S	TEN	TOR.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH EMMA K. 17 DAY 1995 June 4:15 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) # UNDER 1 YEAR # UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign Oct. 15, 1898 212-28-3390 1 M 2 X F 96 YRS. Maryland 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Bel-Forest Nursing Center DIRECTOR Forest Hill Harford RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3808 Hamilton Avenue 21206 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY 3 🔀 Widowed 4 🗌 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe nentary/Secondary (0-12) College (1-4 or 5+) 6th grade Seamstress Clothing Manufacturer 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Sumerne) John Bopp Barbara BE Lang notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Wilder (dahtr) 2408 Gilwood Drive, Joppa, MD 99 20a METHOD OF DISPOSITION
1 ABurtel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Parkwood Cemetery 6/20 Baltimore, Maryland 4 Donation 8 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE it els 9705 Belair Rd., Baltimore, MD 21236 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death the disease or condition 1ek ) nus resulting in death) traumatic event, CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY shows any 1 YES 2 7 NO 1 TYES 2 AND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Boxed{1}\) UNCERTAIN \( \overline{\infty}\) 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 IP Nursing Home 5 - Residence 6 - Other (Spec/ly) 1 YES 2 NO Inpatient 2 - ER/Oulpatient 3 - DOA seath with the S marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 1 Wiltural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 849 6 Could not be COMPLETED 4 Nomicide 28 Item 29e. CERTIFIER

(Check note)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) and manner se stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h 2 \_ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner ee stated. 296, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D14036 6/19/95 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Rene Delos Santos, 2835 Churchville Rd. Churchville, MD 21028



JUN 2 1 1995

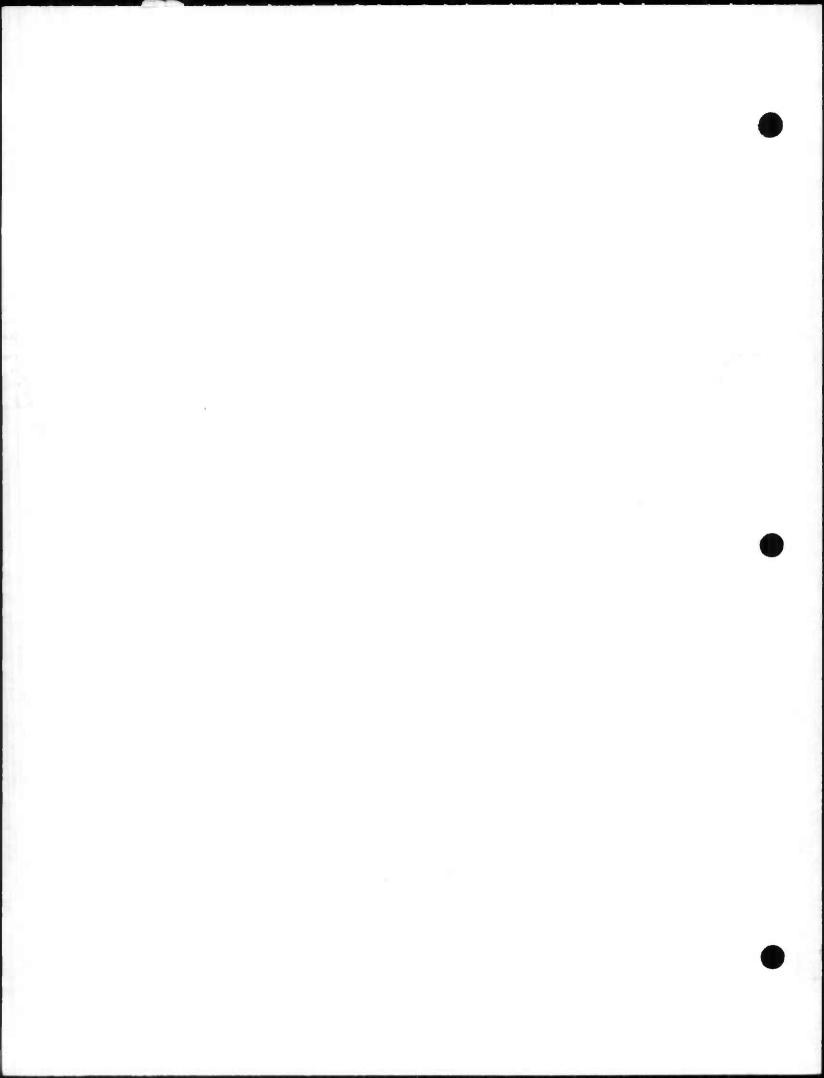
for use as the burial-transit permit. Pages 1, 2, 3 should

Let or attending physician.

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	FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMEN	T OF H	IEALTH DEAT	AND ME	ENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Lest)	Prit	Cheti	_					DATE OF DEAT	H	YEAR 995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-76-3033	5. SEX 1 M 2 V F	6. AGE (In yrs. las	YRS.	IF UNDE	DAYS	# UNDER	24 HRS. 7	APR 19	1959	Country)	TIMORE, MD
OR		SPITAL			9b. CIT		BATO.	OF DEAT	H ITY	9c. COUI	nty of DEA	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  MARYLAND	n/a		10c. CIT	Y, TOWN	DR LOCAT	ION BALTI	MORE				10d. INSIDE CITY LIMITS? 1 VSS 2 ND
FUNERAL	100. STREET AND NUMBER 636 CARRO	LLTON A	VENUE	212	05	101	ZIP CODE	105		10g. CITI	_	STATES
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FDRCES? 1 [ IF YES, GIYE WA	YES 2 V	MED (D		If yes, ap	ecify Cuber	F HISPANIC n, Mexican, I Specify:	ORIGIN? (Specifi Puerto Rican, etc	y Yes or No—	14. RACE - Black, Specify:	American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(G life.	CEDENT'S tive kind of a Do NOT us	vork done e retired.)	during mo	ON st of working	9		RSITY		PITAL
BE CON	17. FATHER'S NAME (First, Middle, Lest) HUGH BROWN						18. MOTH	CLOR	(First, Middle, Me RYBELLE		ISTON	V
TO B	190. INFORMANT'S NAME (Type/Print) ROMAINE PEN	N	.191	MAILING	E. 2	\$ (Street a	nd Number o	or Rural Rou TREET	, BALT	Town, State, Zip I MORE,	Code) MD 2	21218
	20s_METHOD OF DISPOSITION 1 A Burisl 2 Cremation 3 Remo 4 Donation 8 Other (Specify)	val from State	20b. PLACE A cemetery, cre K I N	matory or o	Proispos ther place	SITION (Na	me of PARK	6+		RANDALL		
	21. SIGNATURE OF FUNERAL SERVICE LICE  Valence	ensee	llan	1		NAME AN	D ADDRES	S OF FACIL				
	23. PART I. Enter the diseases, or contained in the conta	iat only one caus	caused the dee on each line			the mo	da of dylr	ng, such a	na cardiac or n	espiratory arr	eat,	Approximate interval Batwe Onset and Dad 2 day
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	aci	OM AS A CONSECUTIVE AS	Lin	7: 1 M (	/NQ4	lefic	iency	y syn	dio	_	1 week
PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to d	leath but not n	esulting (	n the ur	nderlying	cause gi	iven in Pa	PEF	S AN AUTOPSY REDRINED?	å	WERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN: M	DID TOBACCO USE CONTR	IBUTE TO CAU		TH YE			UNC	ERTAIN				YES 2 AN
IYSICI	EXAMINER?	HOSPITAL: 1 Inpetient 2 I	ER/Outpatient 3	□ DOA	OTHE	sing Hom			Other (Specify)			
ву Р	1 Actural 5 Pending 2 Accident Investigation	(Month, Day	; Year)		URY M	1 🗆 1	RK? 'ES 2 🗌	NO	d. DESCRIBE HO			
COMPLETED	3 Suicide 8 Could not be determined	building, of							Bf. LOCATION (Str. City or Town, S	tele)		ite Number,
OMPL	(Check only one)  29a. CERTIFIER   CERTIFYING PHYSIC   MEDICAL EXAMINER											and manner as stated.
TO BE	296. SIGNATORE AND TITLE OF CENTIFIER	1. Vin	di	2	In	ND)	29c, LICEN	SE NUMBE	t6	29d. DATE	SIGNED (M	A Survey Aper)

	2			
30. HAME AND ADDRESS OF PERSON W	10 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P	Print)		
			1/ 1	. 1 . 1
10600	W 1/2/177 L.O	10/	// /. 1	1/ / /
_10701	M. VINETZ WWD	11/1/14	HODRING	Hoseital
		- 1/1/	(IPPOIN)	111111111111111111111111111111111111111
31. DATE FILED (Month Day Char)	32 ARGISTRATS SIGNATURE			77

MATE FILED (MOUNTS 1 1995 32 AFFIST TO STAND TO



BALTIMORE, MARYLAND 21215-0020 Page 6 may be hours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760 requires that the death certificate be executed wit

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF

31. DATE FILED (Month.

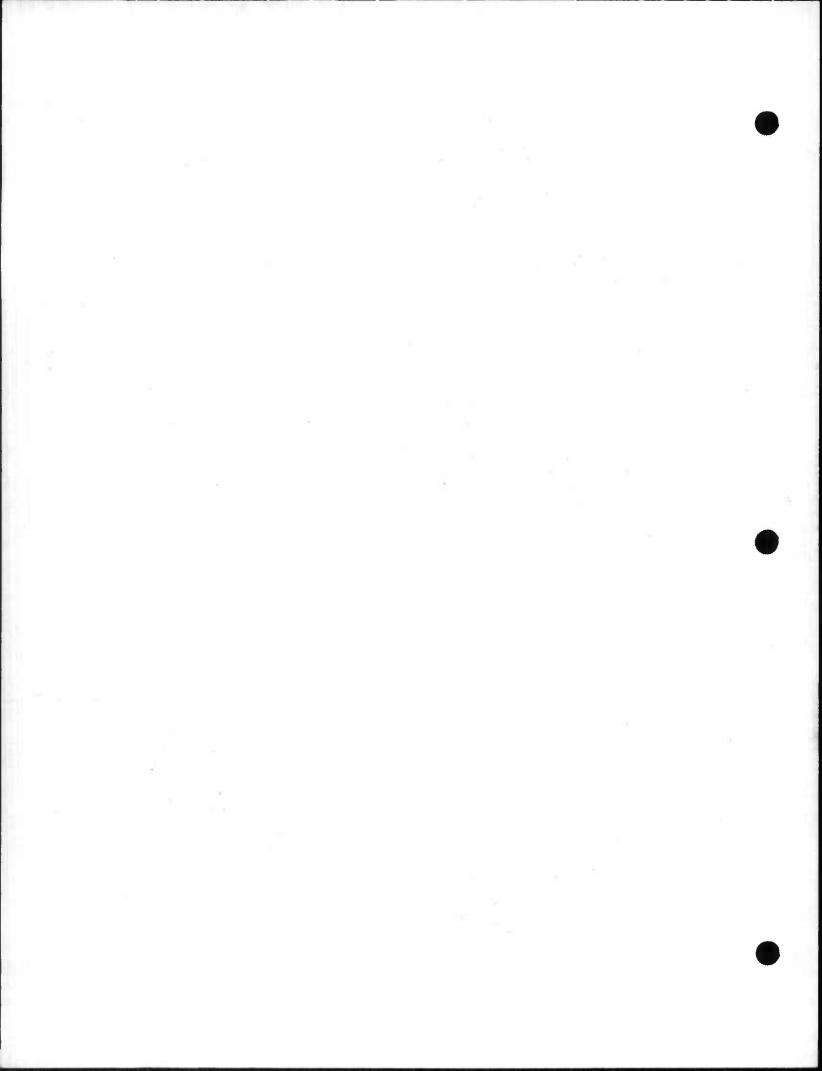
3705ellan

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ANDRE ANTHONY 1995 PETERSON JUNE 14 3:33 Ам 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 9. BIRTHPLACE (St. DAYS HOURS 21 MARCH permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CHADNOR COURT WOODLAWN BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NIA ACTIMORE 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 607 augs dool 21 SA funeral director, page 5 should be detached for use as the burial-transit 21 VE. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. Never Married 2 Married IF YES, GIVE WAR OR DATES BY BLACK Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5 +) Sales person 11+1 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname RAY D LAMS ADRIAN BE NOZ. TEL notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route A 2 HELMINA TO. Md. 21215 ETERSON 2605 GUAJGOO BAC pe METHOD OF DISPOSITION
Burlel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Donation 6 - Other (Specify) 21. SIGNATUA 22. NAME AND ADDRESS OF FACILITY
MARCH FUNERAL HO
4300 WABASH AVE. medical examiner **FUNERAL SERVICE LICENSEE** HOME-WEST E. BALTO. 21215 the filled in by 1 es, or complications that used the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximats Interval Batwe 6 IMMEDIATE CAUSE (Finsi **Onset and Death** cremation, the disease or condition\_ completely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) ending physician and con Hygiene prior to burial, CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate attending physician cause. Enter UNDERLYING CAUSE (Disesse or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 signed by the atte Health and Mental injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any YES 2 NO shows YES 2 NO been t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only bne) Hem certificate t HOSPITAL OTHER: 1 XYES 2 NO 4 - Nursing Home 5 XResidence 6 Other (So the 0 27. MANNER OF DEATH TIME OF 26c, INJURY AT 28d. DESCRIBE HOW INJURY marked, OCCURED this with 1 Netural 5 Pending C M 1 YES After the BY 2 Accident 26e. PLACE OF INJURY - At h 28 is Sulcide 281, LOCATION (Street and Nu COMPLETED Could not be L DIRECTOR: / Homicide determined TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT; If Item 28 29e. CERTIFIER death occured at the time, data and place, and due 295, SIGNATU AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. JUNE 14, 1995 9

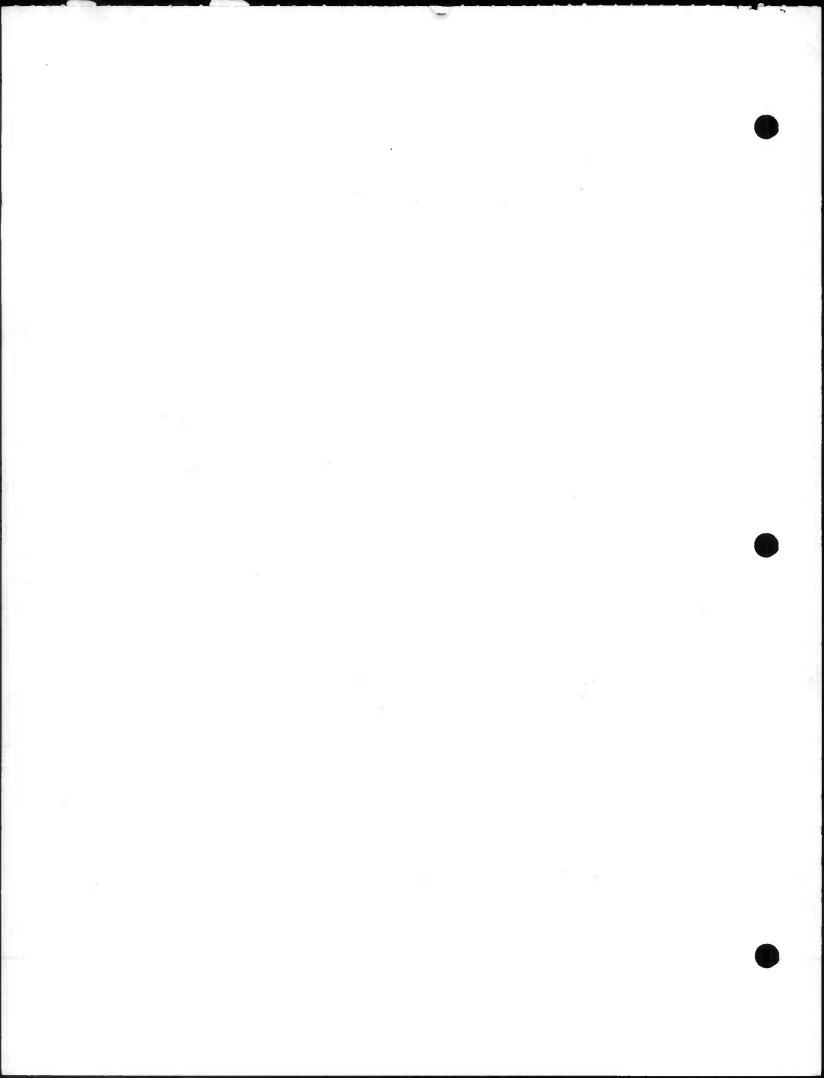
REATH (ITEM 27) (Type, Print)

(F/M)111 Penn Street, Baltimore, Maryland 21201



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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Look)	r,e					DAY A Y	3. TIME OF DEATH
				rs. last birthday)	IF UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	7 199	BIRTHPLACE (State or Foreign
pino		040 54 7000	©XM 2 □ F 6.		MONTHS DAYS	HOURS MIN.	APR. 12,1	934	S. C AROLINA
I, 2, 3 should	TOR	Union Memo	rial Hospi	tal	No.	MO C		9c. COUNTY	n/a
регтіі. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY MARYLAND	n/a		BALTIMOF				10d. INSIDE CITY LIMITS? 1 🖎 YES 2 🗌 NO
ISI	FUNERAL	100. STREET AND NUMBER 1635 DARLEY	AVENUE		101	2121	3	UNITE	D STATES
ding physician. the burial-transit	ВҰ	11. MARITAL STATUS  X Never Merried 2 Merried  3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	. No	13. WAS OEC	ecify Cuben, Mexica	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		RACE — American Indien, Black, White, etc. Specify: BLACK
ital or attending d for use as the	LETED		ION 164 Inpleted) 1-4 or 5+)	Give kind of we life. Do NOT use CHAUFF		ON st of working	166. KIND OF BU		GENCY
the hospital detached fo	COMPL	17. FATHER'S NAME (First, Middle, Last)		011/1011	LOK	18. MOTHER'S NA	ME (First, Middle, Melden		JENO I
5 8 To	BEC	HENRY RIC	Ē				LEE MC TE		CE
y be retained lage 5 should be notified	5	199. INFORMANT'S NAME (Type/Print) DOROTHY MAI	E RICE	19b. MAILING /		PELIAR	ST., BALT		
e 6 ma ector, p		20e. METHOD OF DISPOSITION  1 X VBuriet 2 Cremetion 3 Remova 4 Donation 6 Other (Specify)	I from State cemeters	ACEAND DATE OF COMMENTS OF COM	DISPOSITION (Ne per place)	TERY		CATION — CHY	The state of the s
ter death. Page 6 m the funeral director, wal.		21. SIONATURE OF FUNERAL SERVICE LICENS  Valence	ia Holl	and	WM.		FH1101	E. NOR	RTH AVENUE
in by remedic		23 PART i. Enter the diseases, or com shock, or heart feliure. List	iplications that caused the tonly one cause on each	e deeth. Do no iine.	ot enter the mo-	de of dying, auc	h as cerdiac or resp	iralory arrest.	Approximate interval Batween
E ST E		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	PULMONT		ED	EM			20 min
th certificate be executed anding physician and com I Hygiene prior to burial, or other traumatic ex	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST	DUE TO (OR AS A COM	ACUTO	5 Mya	CARDIA	2 INFA	RA	25 min
Me d	AL CE	PART II. Other significent conditions c	ontributing to deeth but r	not resulting in	the underlying	cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
signed by Health an	EDIC	DIAHERE	HYPER				PERFO	RMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law is b ept.	ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	DEATH YES	NO	UNCERTAIN	4 D		,
en ate	PHYSICIAN: M		26, F OSPITAL:  Tinpatient 2 ER/Outpatien		OTHER:	a & Pastdance	6 ☐ Other (Specify)		
PHYSICIAN: this certifica with the St.	РНҮ	27. MANNER OF DEATH	26e, DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. INJU	URY AT	28d. OESCRIBE HOW	INJURY OCCUR	EO
	ВУ	1 Actival 5 Pending 2 Accident Investigation 3 Suicide # Could not be	260. PLACE OF INJURY A	At home form et		ES 2 NO	281. LOCATION (Street		
CTOR: after	ETED	4 Homicide determined	building, etc. (Specify)	Tome, territ, et	est, motory, ornice		City or Town, Stete)	and Number of H	rural Houte Number,
対域に=	COMPLET		N: To the best of my knowledge On the beele of examination end						ouse(e) end menner ee atated.
표 표절	BE C	290 SIGNATURE AND TITLE OF CENTIFIER	16020 1	n d		29c. LICENSE NUN	IBER	29d DATE SIG	GNEO (Month, Day, Year)
2889	2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type, F	Print)	1151	007	ace h	MTD. NO 21218
5		31. DATE FILES (100T) . 1995 Julio	31 REGISTRAR'S GRATUR		UNITE	V PUE PU	WART A	V. 1	10, NO 42/8



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

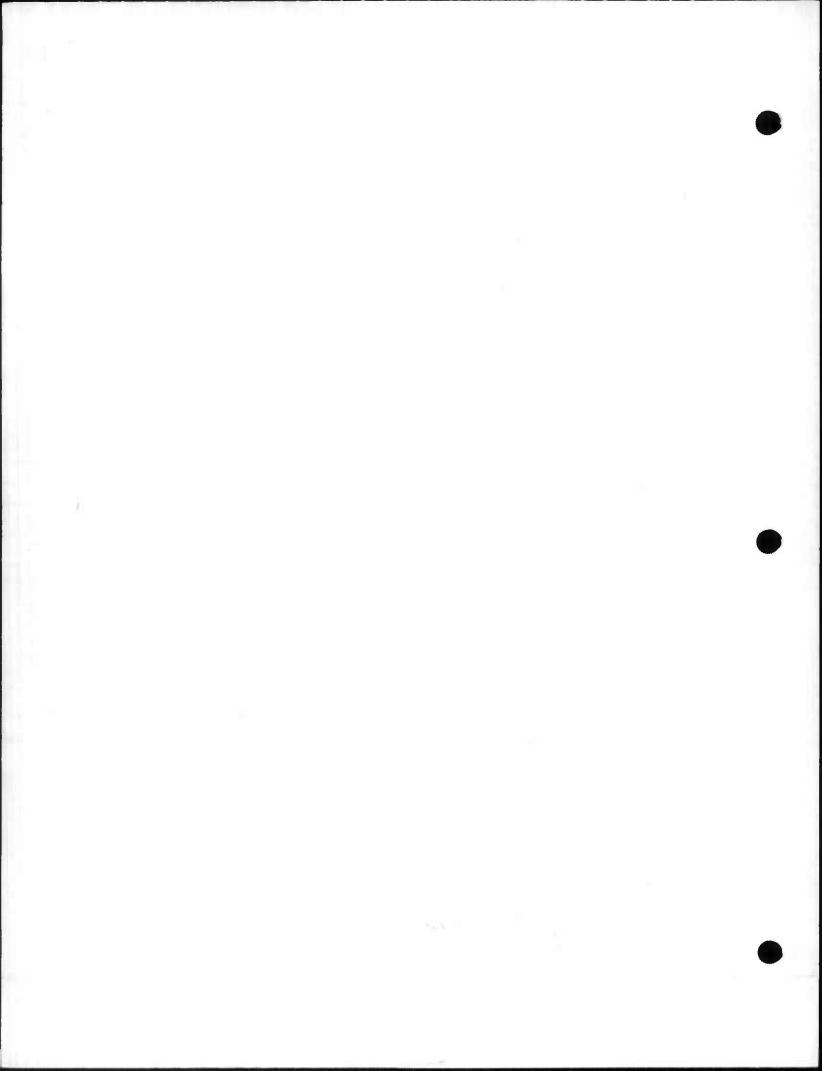
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)							1	2. DATE OF DE	EATH DAY		3. TIME OF DEATH
		Willi:	a m	С.	RIC	KAR	D		June		1995	4:11 pm
1	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last	birthday)	IF UNDER 1		IF UNDER		7. DATE OF BII (Month, Day,	TH Mari	8. BIRT	HPLACE (State or Foreign
- 9		1 № M 2 🗆 F	70	YRS.	MONTHS	DAYS	HOURS	MIN.	11/27/			yland
-	9a. FACILITY NAME (If not institution, give str				9b. CITY, 1	OWN C	R LOCATI	ON OF DE			c. COUNTY OF	
0	Memorial Hospit	tal of I	Easton		E	as	ton				Talbo	t
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY	Y, TOWN OR	LOCAT	ION					10d. INSIDE CITY
FIG	Maryland Caro	line					F	aha'	ralsbu			LIMITS?
AL	10e. STREET AND NUMBER					10f	. ZIP CODI		Taisbo		g. CITIZEN OF	WHAT COUNTRY?
E I	202 Brooklyn A	venue						2 1	632	U	nited	States
FUNERAL	11. MARITAL STATUS  Control 2 Married	12. WAS DECEDENT	EVER IN U.S. ARE	MED	13. W	S DEC	ENDENT C	F HISPAN	HC ORIGIN? (Spe n, Puerto Ricen,	city Yes or I	No- 14. RAC	E — American Indian, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				2XXNO			etc.)		olly: Black
	15. OECEDENT'S EDUC	WW II		CEDENT'S	USUAL OCC	HPATIC	nau .		Tab VIIII	OF BUILDING	SS/INDUSTRY	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(GA	ve kind of w Do NOT us	rork done dui	ing mo:	st of working	ng				
릴	Ninth	dollage (1-4 of 5+)		Tru	ck Di	riv	rer		Tru	ckin	g	
ő	17. FATHER'S NAME (First, Middle, Last)							HER'S NA	ME (First, Middle,	Maiden Sum	neme)	
BE (		Genera1	Ricka	rd			M	ary	Sande	rs		
2	19e. INFORMANT'S NAME (Type/Print)						nd Number	or Rural F	Route Number, City	or Town, St		
	Annie R. Woods		2	02 1	Brook	:1 у	n A	ve.	, Fede	rals	burq,	MD 21632
	20s. METHOD OF DISPOSITION  t DXBuriel 2 Cremation 3 Remove	val from State	20b. PLACE A cemetery, cren	ND DATE O	FDISPOSITI	ON (Na	me of		DATE	20c. LOCATI	ION — City or 1	own, State
	4 Donation 8 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	East	ern			Vet		1\$ 23	Hur	lock,	Maryland
	-m. 0 01	56			Fra	mp	tom-	- На и	vkins-	Esko	w Fun	eral Home
_ 3	Muchay T.	skin			I O	DO	X 4,	3, E	edera	lsbu	ra. Mi	D 21632
	23. PART i. Enter the diseeses, or co shock, or heart failure. Li	omplications that lst only one caus	caused the dea a on each line.	ith. Do n	ot enter th	a mo	de of dyl	ng, sucl	h aa cardiac o	r reapirato	ory arrest,	Approximata interval Between
	IMMEDIATE CAUSE (Final disease or condition	8										Onset and Death
	resulting in death)	266	SLS DR AS A CONSEO	UENOE OF								12 hours
-		(ACI)	1ary	Tra	ct :	In	fee	4,	1.4			3 Paul 5
2	Sequentially list conditions, if any, leading to immediate		D AC A CONCEO	HENCE OF								3
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	Metas	textic,	Cala	on c	A	to 1	live	r, Splee	ent	lung	6 Morth
Е	that initiated eventa resulting in death) LAST	DUE TO (C	OR AS A CONSEC	UENCE OF	):							
CERTIFICATION	d.											
	PART II. Other algnificant conditions	contributing to d	eeth but not re	aulting is	n the unda	rlying	ceuse g	lven in		NAS AN AUT		b. WERE AUTOPSY FINDINGS
EDICAL	Hepatic failur	و	ANEI	nia					1 0	VES 2 2	NO NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä	Ronal Failure	2	Hype	rka	dem	0			_   ' '	1		OF DEATH?
ä	DID TOBACCO USE CONTRI	IBUTE TO CAU	SE OF DEAT	H YE	S   NO	0 🗆	UNC	ERTAIN	N.EX			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	H (Check onl	y one)						
Ιλ		HOSPITAL:			4 - Nursin	g Home	5 🗆 Re	eldenca	6 Other (Spec	ffy)		
	27. MANNER OF DEATH  Netural 5 ☐ Pending	28e. DATE OF III (Month, Day		28b. TIME INJU	JRY	Ic. INJU	RK?		28d. DEŞCRIBE	HOW INJUR	RY OCCURED	
B	2 Accident Investigation	20. BLACE OF	INJURY — At hon				ES 2 _	NO				
2	3 Suicide 8 Could not be 4 Homicide detarmined	building, at	c. (Specify)	ne, term, a	treet, ractory	, office	1		28f. LOCATION City or Town	(Street end N , State)	Number or Rural	Route Number,
COMPLETED	29a. CERTIFIER	1										
₹ P	(Check only one)  296. CERTIFIER CERTIFYING PHYSICI CONE ONE)  2 MEDICAL EXAMINER:	On the basis of axa	y knowledge, dear mination end/or in	th occurre	d at the time	, date	end place,	end due	to the cause(e) a	nd menner	ee atated.	
	296. SIGNATURE AND TITLE OU CERTIFIED				i, iii iiiy opii	1						
B	Much let	Joens	w				29c. LICE	WY NUM	OS 5	290	d. DATE SIGNE	(Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM	27) (Tvoe	Print)						6/1	0[7]0
	Michael Lees,					. т	ane	E -	eton	MD	21601	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR	SOGNATURE	0 0 111	11	. 1	alle	, Ec	, 11000	MD	21001	
	JUN 2 1 1995 Jul	of animarior.	markall									





DIVISION OF VITAL RECORDS, P.O. BOX 68760

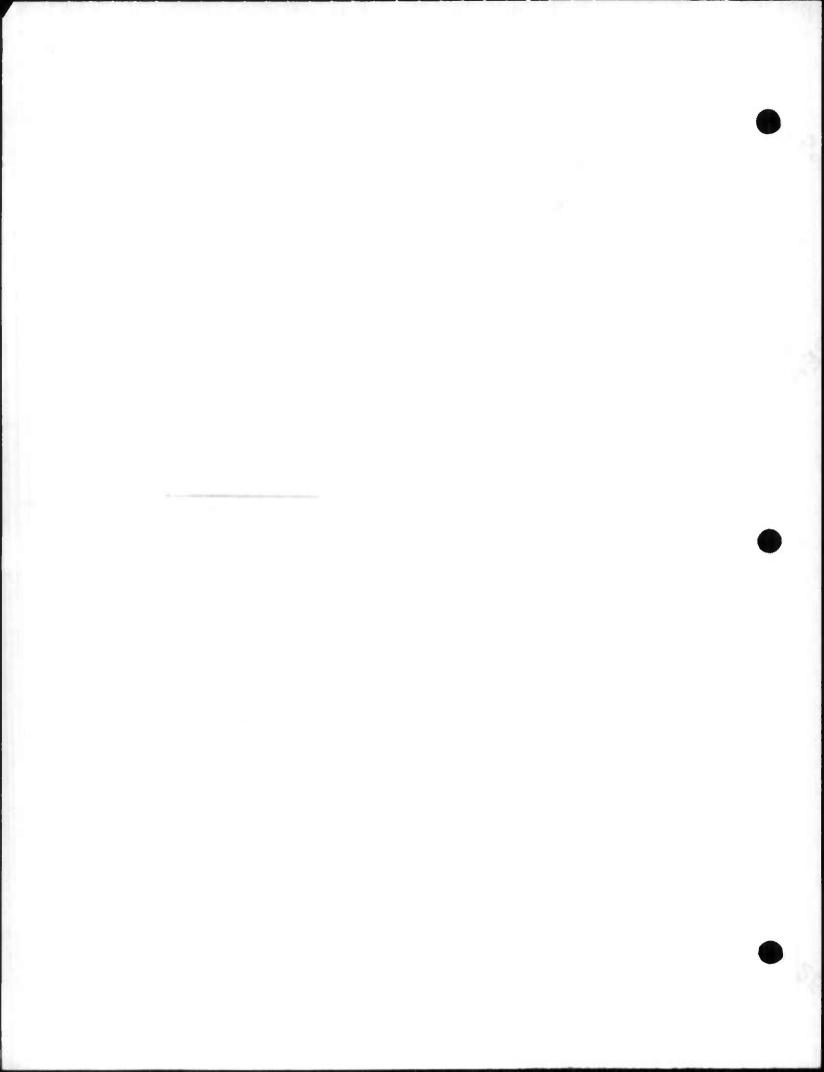
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	- 10											HEG. NO			
	i	1. DECEDENT'S NAME (First,	, Middle, Last)									OF DEATH			3. TIME OF DEATH
			Hel	en V. S	tofoncki						MONT			YEAR	2:20 P. w
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.		ne 10.	199		IPLACE (State or Foreign
		014 10 0000		1 🗆 M 25 F	83	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Year)	_	Count	Y)
	ļ	214-12-3503 9a. FACILITY NAME (# not in	- Ale - Ale		03							14-191			aryland
1,	~	Manor Car					9b. CITY			ION OF DE	EATH		1	NTY OF D	
3	፬ ∦	RESIDENCE OF DEC		5011				10	wson				1 1	3alt:	imore
}	2	10a. STATE	10b. COUNTY	,		Inc. CIT	Y, TOWN (	OR 1 0041	TION.						
9	DIRECTOR	Maryland	Balt			100.01	Tows		ION						10d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER					TOW.								1 _ YES 2 1 NO
13	\$		T	- D 3 :				101	. ZIP COC	_			10g. CIT		VHAT COUNTRY?
ÿ		302 E.	. Joppa	a Road, i	Apt /II				21	286				U.S.	.A.
18	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT	OF HISPAN	VIC ORIGII	N? (Specify Yes	or No-	14. RACE	— American Indian, k, White, etc.
	2	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE	WAR OR DATES			1 YES	2 NO	Specify	n, ruento y:	Rican, etc.)			"y White
															wiiice
Į į			EDENT'S EDUC y highest grade		(G)	CEDENT'S	vark done	CCUPATIO	ON ast of work	na	168	, KIND OF BUS	SINESS/INC	DUSTRY	
į,	4 II	Elementary/Secondary (0	1-12)	College (1-4 or 5	116a	Do NOT us	e retired.)								
e 9		12			Une	mploy	ment	In	sura	nce		State	of Ma	aryla	and
Once.	<u>ةِ ا</u>	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOT	HER'S NA	ME (First,	Middle, Malden	Surname)		
10 m		Victor Si	ikorski	Ĺ						Caro	olin	e Aug	istar	owic	17
E 0	- 11	19a. INFORMANT'S NAME (7)	ype/Print)		198	. MAILING	ADDRESS	S (Street a	nd Numbe			ber, City or Town			
examiner must be notified at once	- 1	Dorothy Jac	ckson M	Miller								ore, M			21224
٥	H	20a. METHOD OF DISPOSIT			20b. PLACE					, Da	DAT		CATION -	_	
2		1 ☑ Buriel 2 ☐ Crematio 4 ☐ Donation 6 ☐ Other		oval from Stata	cemetery, crei	matory or or	ther plecel			14	1			,	
9	- 1	21. SIGNATURE OF FUNERAL		ENSEF	Park	wood		-		SS OF FA		Pa:	rkvil	le,	Maryland
Ē	ĺ				/ /							al Home	e. Tr	ıc.	
medical ex		▶ Wal	race	J. 13	100 S1, J	1,						owson,			14
ws any injury, or other traumatic event, the EDICATION	- 15	IMMEDIATE CAUSE (Findisease or condition resulting in death)  Sequentially list condition from the sequentially list condition on the sequential sequentia	iona, dileta NG ry	DUE TO	(OR AS A CONSEC (OR AS A CONSEC	DUENCE OF	7): 7):					24a. WAS AN PERFOR		24b.	Onset and Death  O 439  WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
E 5	ś II											1 TYES 2	B NO		COMPLETION OF CAUSE OF DEATH?
2 2	3														1 TES 2 WO
N N		DID TOBACCO U		RIBUTE TO CA					TUNC	ERTAIN	4 D				
VSICIAN	3	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLAC	E OF DEAT	H (Check								
S >	2	1 YES 2 THO			ER/Outpatient 3	□ DOA			• 5 □ R	aldence	8 🗆 Othe	r (Specify)			
		27. MANNER OF DEATH	Donallas	28a. DATE OF (Month, D	INJURY ey, Year)	26b. TIM	E OF URY	28c. INJI WO			26d. DES	CRIBE HOW I	JURY OCC	CURED	
BY PH			Pending investigation			14112	M		ES 2	NO	1				
			Could not be	28a. PLACE O building,	F INJURY — At hor atc. (Specify)	ne, farm, a	fraat, fact	ory, office			281. LOC	ATION (Street a	nd Number	or Rural A	oute Number,
TE TE	: L	4 Homicide	detarmined								Only	or lowing State)			
MPORIANI: II IIEM 28 18  O BE COMPLETED				CIAN: To the best of R: On the basis of a											and manner as stated.
₹ O		29b. SIGNATURE AND TURE	$\sim$					1		ENSE NUM			-	-	(Morrin, Day, Year)
E E			10	ms m	)				1	) O	13	,	▶ ()	1/2	(Co
	2	30. NAME AND ADDRESS OF				27) /5	Delant		1	dy	1		- 7	14	45
								Пот-	202	MA	212	0.4	/		
	-	31. DATE FILED /Month / Deck	nuallis	M.D. 7	and date	I DE.	rve,	TOM	son,	rid.	212	U4			
6		31. DAT JUN 271 79	95 Ja	A SUMMAN	, a see Arone										

BALTIMORE, MARYLAND

5	A		-
10 THE HOSH IAL OH AT LENDING PHYSICIAN: The Jaw requires that the death certinicate be executed within 24 hours after death. Page 5 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be		IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified #
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	1tem22, g-724, b-21-9	o,perr.n.,ak						
_	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		ENTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)  LYNETTE	SI	HAW			2. DATE OF DEATH	" 19 <sup>8</sup> 9	3. TIME OF DEATH 11:04 PM
=	4. SOCIAL SECURITY NUMBER 134-32-0028	1 □ M 2 🖾 F 5	yrs. last birthday)  YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9/12/194		BIRTHPLACE (State or Foreign Country)  W York City
TOR	99. FACILITY NAME (If not institution, give s  GREATER BALTIMORE  RESIDENCE OF DECEDENT		TER	9b. CITY, TOWN OF TOWSON	R LOCATION OF DEA	тн	9c. COUNTY BALTI	
ပ္ပ	100. STATE 10b. COUNTY	,	100 CITO	Y, TOWN OR LOCAT	10M			
L DIRECTOR		Ltimore		Woodlaw				10d. INSIDE CITY LIMITS? 1 YES 2 KNO
FUNERAL	349, 142-14	3 2 2 2 3		101.				OF WHAT COUNTRY?
I K	5 Kafern Drive	12. WAS DECEDENT EVER IN	U.S. ARMED	12 WAS DEC	21207	ORIGIN? (Specify Yes		JSA
	1 Never Married 2 Merried	FORCES? 1 YES	2 1 NO	If yes, spe	cify Cuben, Mexicen,			RACE — American Indian, Black, White, etc.
ì	3 Widowed 4 Divorced	TES, GIVE WAN ON DA	163	1 TYES	2 NO Specify:			Specify: Black
TEO	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coflege (1-4 or 5+)		USUAL OCCUPATIO rork done during mose e retired.)		16b. KIND OF BUS		
1	12th	2	Medi	cal Re	cords	Peni	tenti	ary
COM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	E (First, Middle, Malden	Surname)	
BE (	Leroy Clark				Louis	se Walla	ce	
TO B	19e. INFORMANT'S NAME (Type/Print)					ute Number, City or Town		
-	Davant Cooper		#4 D	uke of	Windsor	Apt.	102 B	alto., MD.
	20a. METHOD OF DISPOSITION 1 □ Burlel 2 15 Cremetion 3 □ Remo		PLACE AND DATE Of	F DISPOSITION (Na	me of	DATE 20c. LO	CATION — City	or Town, State
	4 Donatlog 5 Other (Specify)	Me	tro Cr	emator	y 6	1/23 Cat	onsvi.	lle, MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC	7 i ( )	n-A		D ADDRESS OF FACIL		N FIIN	ERAL HOME
	Nroll	C. My						
	23. PAST I, Enter the diseases, or c	complications that caused List only one cause of each	the death. Do n	ot enter the mo	Liberty	Heights	Jy arreat,	
	IMMEDIATE CAUSE (Final			/	,			Interval Between Onset and Daath
	disease or condition	Cercl	ocla	her	norrha	se.		3 DAYS
	The state of the s	DUE TO (OR AS A	CONSEQUENCE OF	):				
NO	Sequentially list conditions.	h						
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	):				
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A (	CONSEQUENCE OF	):			<u></u>	
듄	resulting in death) LAST			,				İ
뜅		l.						
¥	PART II. Other aignificant condition	s contributing to death bu	t not reaulting is	n the underlying	cause given in Pr	ert I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL	101	y puteus, o	4			_ 1 _ YES 2	NO NO	COMPLETION OF CAUSE OF DEATH?
×						_		1 - YES 2 - NO
PHYSICIAN:	DID TOBACCO USE CONTR				UNCERTAIN	₩ I		
S	EXAMINER?	HQSPITAL:	6. PLACE OF DEAT	OTHER:				
¥ S	1 VES 2 NO	1 Propertient 2 ER/Outper			5 Reeldence 6			
	1 Netural 5 Pending	(Month, Day, Year)	26b. TIME	JRY WOI	RK?	6d. DESCRIBE HOW II	NJURY OCCURE	D
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY -	At home form of		ES 2 NO	THE LOCATION (Owner		
TED	4 Homicide 6 Could not be	building, etc. (Specif	y)	neet, rectory, ornes		Eff. LOCATION (Street e City or Town, State)	nd Number of H	urai Houte Number,
COMPLETED		CIAN: To the best of my knowle R: On the basis of exemination						
	296. FIGHATURE AND TITLE OF CERTIFIER			., my opinion, or				
TO BE	mandras	Mare /	an	MO	D 2-1	778	•	6/17/91
	30. NAME AND ADDRESS OF PERSON WHO CHANDRAS EICH A	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, 560 /	BLV)	RAVEN	BALTI	MORO	21239



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DIVISION OF VITAL RECORDS, I	ì
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		1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		NENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Lest) WILLIAM A	NDREW	SMI	TH		2. DATE OF DEATH MONTH JUNE	7. 199	3. TIME OF DEATH
2		274-01-2507	XM2□F 8		IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) SPONSYLVANIA
2, 3 should	TOR	9a. FACILITY NAME (If not institution, give street  SIANI HOSPI+AL  RESIDENCE OF DECEMENT			_	IMBRE		Bc. COUNTY	OF DEATH
t, Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY	imore		TOWN OR LOCAT		-		10d. INSIDE CITY LIMITS? 1 YES 2 NO
n. Insit permi	FUNERAL	100. STREET AND NUMBER 4 SAN DYCOU	Rt			ZIP CODE	27		OF WHAT COUNTRY?
215-0020 attending physician. ise as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPANI ecify Cuban, Mexican 2 NO Specify:			RACE — American Indian, Black, White, etc. Specify: While
21 Page 17	COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ON opleted)	life. Do NOT use	rk done durina ma	st of working	Section 100 Process	ISINESS/INDUST	
YLAND  I by the hospit  I be detached  at once.	l m	17. FATHER'S NAME (First, Middle, Last) MARK A, SM	nith	2,400	20110	18. MOTHER'S NAM	E (First, Middle, Meider	Surname)	
E, MAR y be retained to bage 5 should be notified		BRUCEA. Sm		196. MAILING A 5 PAL	O CIRL	IND Number of Rural Ru LE HAH	oute Number, City or Tov	rn, State, Zip Coo	2/2/27
TOR e 6 ma nector, 1		20e, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal Constion 6 Other (Specify) 21. SEDIATURE OF FUNERAL SERVICE LIGHT	1/1	PLACE AND DATE OF the ry, crematory or othe LLCRCS7	ar place)	eterx6	123/55CU		AND MACYLAN
- 9 -	Ц	23. DART I. Enter the discess, or com	plications that caused	the death, Do no	132	8 SULPI	HUR SAR	INGIRE	MARYLAND AD 21227
fithin 24 hours after letely filled in by th emation, or remove mt, the medical		shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) a	only one ceuse on ee	ch line.		Shock		matory arreat,	Approximata Interval Between Onset and Daeth
executed with and complete b burial, crem matic event,	NO	Sequentially list conditions,	BOC DUE TO OR AS A	Terial	Sep	sis			7 Days
P.O. BOX h certificate be anding physician Hygiene prior t or other traus	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO OR AS A	CONSEQUENCE OF):	lure				10 Days
RECORDS, P requires that the death been signed by the atter of Health and Mental is shows any injury, o	일	PART II. Other algolificant conditions of	ontributing to death but	t not resulting in	the underlying	couse given in F	Part I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL RI e law req has been Dept. of	SICIAN: N	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAIN			1 NES 2 NO
CIAN TI CIAN TI Certificate the State	IYSIC	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	OSPITAL:	tlant 3 DOA 4		e 5 Residence 6			
ON OF DING PHYSIC After this ce death with th	ву РНУ	1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	M 1 1	RK? /ES 2 NO	28d. DEŞCRIBE HOW	NJURY OCCURE	D
S TEN TOR:	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, atc. (Specif	— Al home, farm, str y)	eet, factory, office		281. LOCATION (Street City or Town, State	and Number or Ri	ural Route Number,
- 보기 가 보	로	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAI EXAMINER: C							use(a) and menner as stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	BE	296. SIGNATURE AND TITLE OF CERTIFIER	M Pos	don't Ph	vicinia h	29c. LICENSE NUME	DER 1-JL9836	29d. OATE SIG	INED (Month, Day, Year)
0=	10	30. NAME AND ADDRESS OF PERSON WHO CO JOHN A. LIPP	ERT, MD	TH (TEM 27) (Type, P	INAL	HOSPI		JUNE	1/1 17/3
		31. DATE JURI 2011 0 1995 July	ERT, MD	tel,		11	F 1 60		

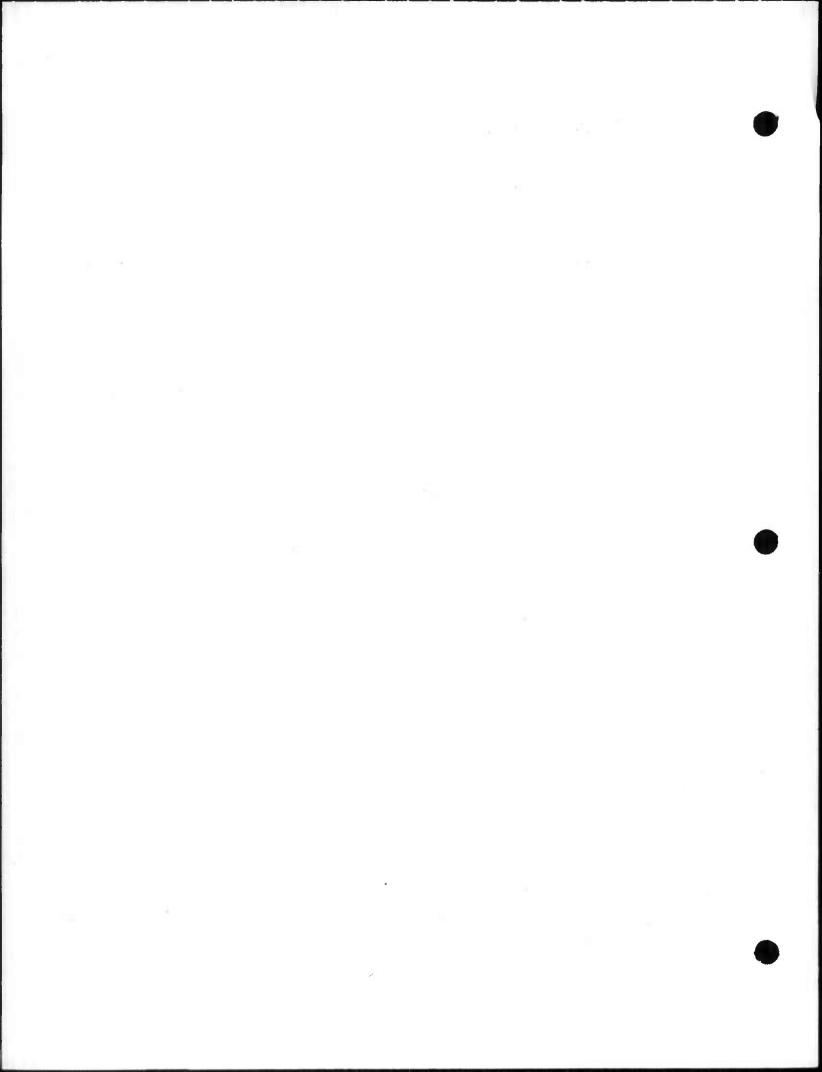
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5.5 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

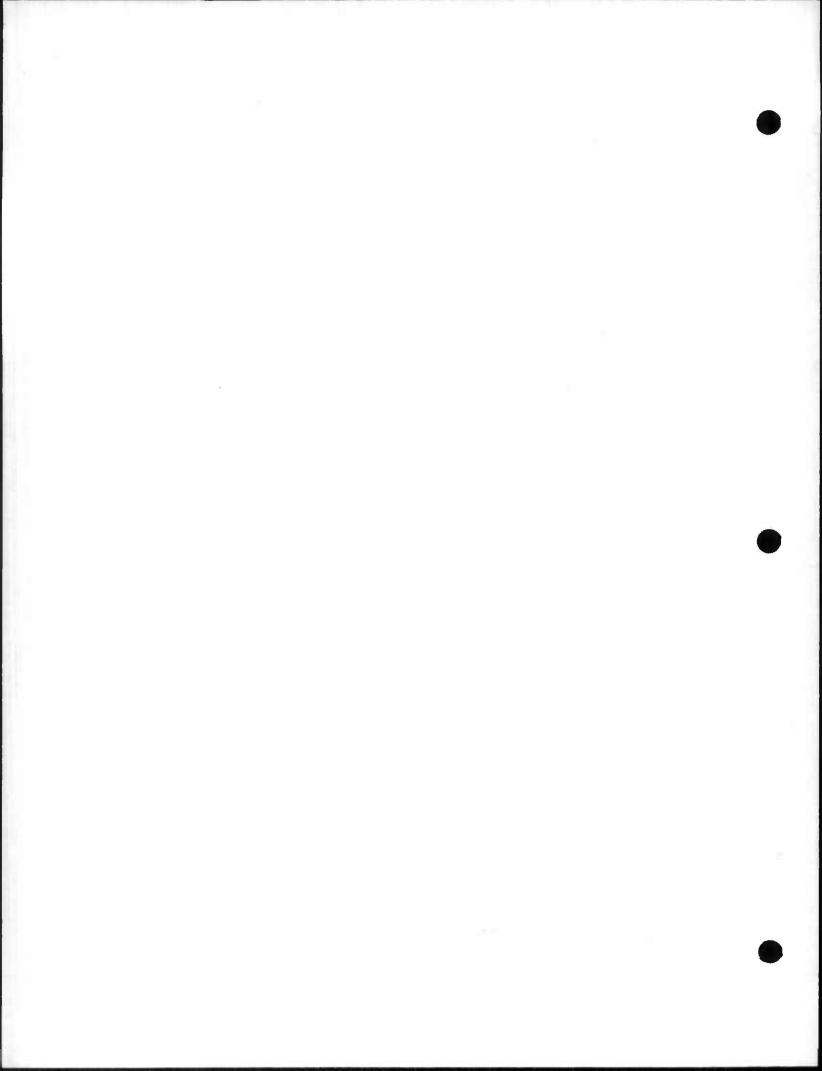
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF	HEALTH AND	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	1. THOM	A Thoma	as		2. DATE MONT	June	7179	PEAR -	ME OF DEATH	Ам
	4. SOCIAL SECURITY NUMBER 217-26-2181  9a. FACILITY NAME (If not institution, give :	1 □ M 2 XJXF	(In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mgr	OF BIRTH	21	GREENV	(State or Foreign	
TOR		ENERAL HOSPI	TAL		LTIMORE		ITY	9c. COUNT	Y OF DEATH	'a	
. DIRECTOR		v 1/a	10c. CITY	TOWN OR LOCA	TION ALTIMORE				10d.	INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER 4009 NORFOLK	AVENUE		10	f. ZIP CODE 2121	16		UNIT	ED S	STATES	
Β	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 (X))(D	13. WAS DEC If yes, sp 1 YES	CENDENT OF HISPA Healty Cuban, Mexico 2 XNO Specific	NIC ORIGI nn, Puerto ly:	N7 (Specify Yea Rican, etc.)	or No— 1	4. RACE — An Black, Whit Specify:		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 8 TH	Cation ocompleted) College (1-4 or 5+)	16a. DECEDENT'S & (Give kind of we life. Do NOT use ELDERLY-	ork done during me retired.)	on ost of working NG ASST.		STATE	OFFIC		LDING	
	17. FATHER'S NAME (First, Middle, Last)		LLDLKL1-	- 1101/31	16. MOTHER'S NA	ME (First,	Middle, Maiden	Sumame)	E BUI	LDING	
TO BE	JOHN PRICE  19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	BARAH Boute Nun		n, State, Zip C	ode)		$\dashv$
-	JOSEPH TH	OMAS II	4009	F DISPOSITION (N	ame of	/E, B	BALTIMO		D 212 by or Town, St		$\dashv$
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LI		GARRI'SON"		V A CE	M.6-		WINGS		S,MD	
	X. Valence	ea Holl		WM.	C. MARC	H FF				AVENUE	Е
	23. PART i. Enter the diseases, or shock, or heart feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Probab	d the deeth. Do not bech line.  Le Acute A CONSEQUENCE OF	e Myoca				ratory arres		Approximate interval Between Onset and Da	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS /	re Arten Consequence of Vein Th Consequence of	:		Caro	diovas	sular	Dise	ase	
EDICAL C	PART II. Other algolificent condition	na contributing to deeth b	out not reaulting in	the underlyin	g cause given in	Part i.	24e. WAS AN PERFOR	IMED?	AMAIL	AUTOPSY FINDIN ABLE PRIOR TO LETION OF CAUSI ATH?	
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	F DEATH YES	S □ NO □	UNCERTAI	N 🗆			10	YES 2 NO	
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 XNO	HOSPITAL:		OTHER:	e 5 🗆 Residence	6 Othe	et (Specify)				$\exists$
<u>_</u>	27. MANNER OF DEATH  1 Netural 6 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	DF 28c, IN.	URY AT IRK?		SCRIBE HOW I	NJURY OCCU	RED		$\exists$
TED B	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, ferm, et			28f. LOC City	CATION (Street a or Town, State)	and Number or	Rural Route N	umber,	$\dashv$
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my know	ledgs, death occurred	at the time, data	and place, and due	to the ca	use(a) and mar	ner as stated	cause(a) and n	nanner as stated	d.
BE	29b. SIGNATURE AND TITLE OF CERTIFIES	72	3		29c. LICENSE NUI			29d. DATE S	BIGNED (Month	, Day, Year)	$\dashv$
2	36. HAMS AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, )	Printo	D46°			-06	5/17	195	$\dashv$
	JUN 2 1 1995	La Dantenar Nam	yland (	Genera	l Hospi	tal	827 ]	inde	n Ave	nue	$\dashv$



DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	nours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

	1 - STATE OF MARYLAND REGISTRAR	/ DEPAR					MENTA	REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)		IOAIL	. 01	שבאו	-	2. DAT	E OF DEATH			3. TIME OF DEATH	
,	WILLIAM H. TODD						MON		199	YEAR	300 pm	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.	iast birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH	199		PLACE (State or Foreign	
	218-42-0252 XIM2DF 49	YRS.	MONTHS	DAY8	HOURS	MIN.	(Mon	27-19	45	Country	1)	
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY,	TOWN C	R LOCATIO	ON OF DE		21-19		NTY OF D	yland	
S	Johns Hopkins Bayview M.C		Ba	lti	more				Ba 1	t.im	ore City	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY											
H			10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?		
-	Maryland Baltimore	Du	Dunda1k								1 TES 2 NO	
RA	1900 Willow Spring Rd.		101. ZIP CODE 2122								HAT COUNTRY?	
FUNERAL		ARMED	12.1	MAR DEC			HC OBIO	A22 (Paralle Mar		SA	A	
F	1 Never Married 2 Married FORCES? 1 X YES 2	NO	11	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify to If yes, specify Cuban, Mexican, Puerto Rican, atc.)  1 ☐ YES 2 X NO Specify:					or No-	Black	American Indian, White, atc.	
В	3 Widowed 4 Divorced Viet Nam		_   _ '	☐ 1E3	Z A) NO	Specify	/:			Specif	White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	DECEDENT'S (Give kind of	USUAL OC	CUPATIO	N et of worklo		16	b. KIND OF BUS	INESS/IND	USTRY		
9	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT u	se retired.)		at Or WORKIN							
₩		ispat	che	r				Trans		ati	on	
BE												
2											43 01000	
	JoAnn Todd 1900 Willow Spring Rd Baltimore, Md											
	20a. METHOD OF DISPOSITION 1 M Burdet 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of camelery, crematory or other place)											
	4 Donation 6 Other (Specify) Holly Hill 6-24 Baltimore, Md  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY											
	· Anthony Cot Con	mel	1. 0	conr	ell;	y F	une.	ral Ho Point	me o	of I	Oundalk	
	23. PART i. Enter the diseasea, or complications that caused that ahock, or heart fellure. List only one cause on each life.	death. Do	ot witer	the mo	da of dyle	ng, auch	n aa car	diac or reapir	atory arr	eat,	Approximata	
	IMMEDIATE CAUSE (Final											
	disease or condition CARD/O PULMONARY FIRES 7  DUE TO (OR AS A CONSEQUENCE OF):										15mb	
	DUE TO (OR AS A CONSEQUENCE OF):											
8	Sequentially flat conditions.  DUE TO (OR AS A CONSEQUENCE OF):  COROMARY ARTERY DISEASE											
CERTIFICATION	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
FIC	Cause. Enter UNDERLYING CAUSE (Disease or injury)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
	ő					-						
CAL	PART II. Other algnificent conditions contributing to death but not	resulting	In the un	derlying	ceuse g	Iven in	Pert I.	24a. WAS AN A		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă							_	1 🗆 YES 2	NO		COMPLETION OF CAUSE OF DEATH?	
MEDI							_				1 - YES 2 - NO	
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE				UNC	ERTAIN	1 🗆					
0	EXAMINER? HOSPITAL:	ACE OF DEAT	OTHER									
PHYSICIAN:	1 ☐ YES 2 7 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient  27. MANNER OF DEATH 28e. DATE OF INJURY			-		idence		er (Specify)				
	1 Netural 5 Pending (Month, Day, Year)	266. TIM INJ	URY	28c. INJU			28d. OE	SCRIBE HOW IN	JURY OCC	UREO		
BY	2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At I	home term i	tireet facto			NO	281 1 00	CATION (Street ar	ad Altreach as	as Down ( D		
윤	4 Homicide determined building, atc. (Specify)		rivot, India	ny, ome			City	or Town, State)	Number	or nurer n	oute Number,	
COMPLET	298, CERTIFIER	4	1.46									
Centifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as stated.    Check only one)   Check only one)												
	29b. SIGNATURE AND TITLE OF CERTIFIER	- Arreangeno	···, iii my op	renon, de				s and piece, and				
R	Savinde UTulle	y.n			29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)	
2	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	FM 27) /3/0-	Print		D	41	100			0/4	0/27	
	SAVINDER K TUILS ? A	You	LODE	011	14.1	1	11	danc	712	7.2		
	31. DATE FILEO (Mopth, Day, Spar)	,000	-	v (2		10		come	772	···	MI	
	JUN 2 1 1995 1000 1000 1000 1000 1000 1000 10											



BALTIMORE, MARYLAND 21215-0020

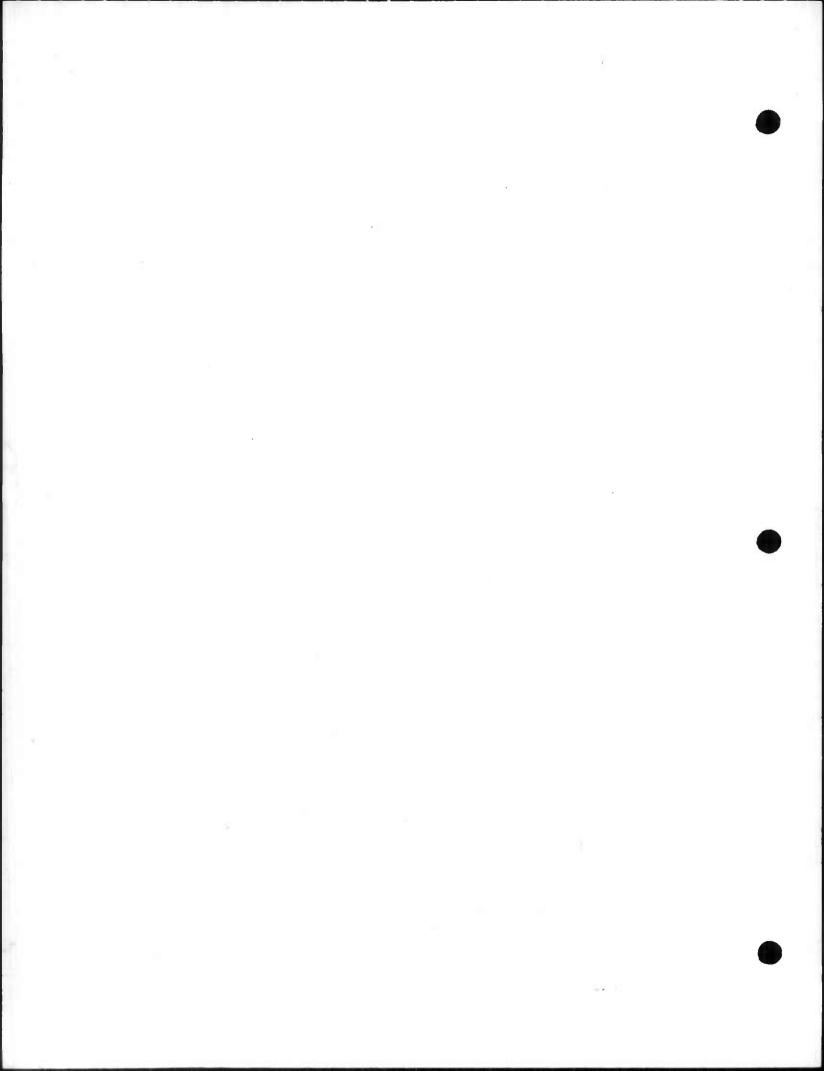
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

#MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

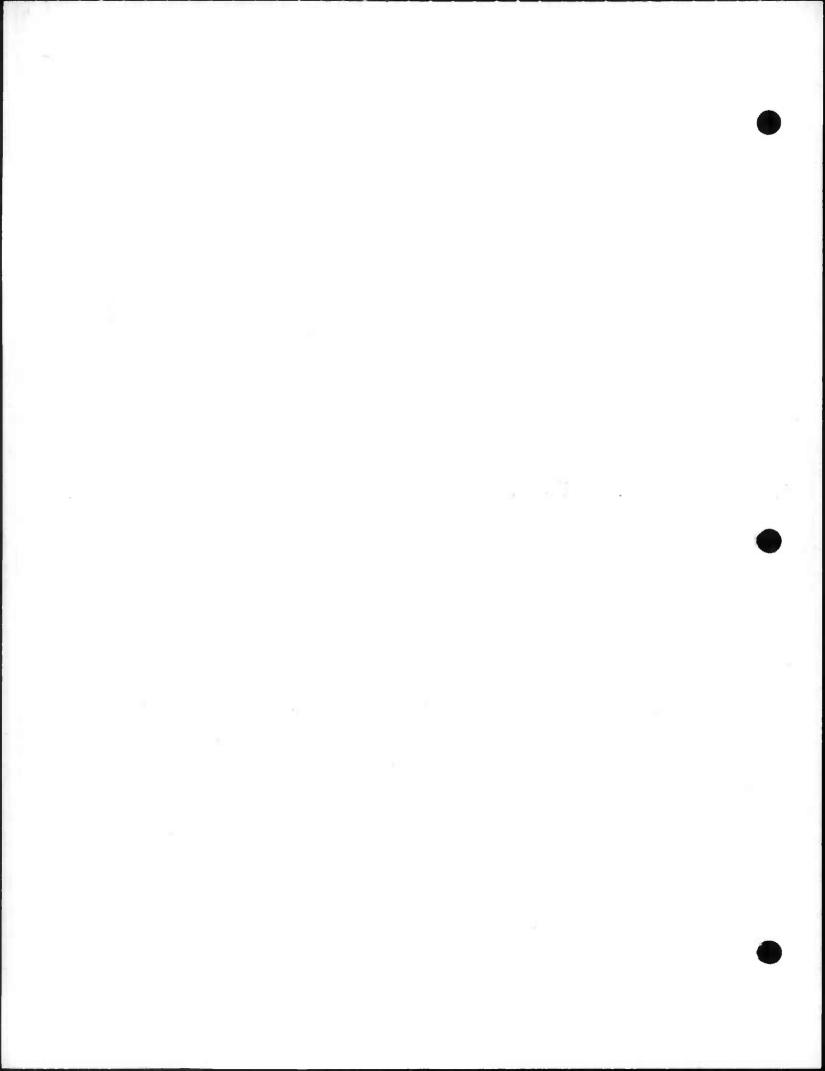
	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT OF	HEALTH AND I	MENTAL HYGIEN						
	1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA	AY YEA	3. TIME OF DEATH				
			ompson			JUNE 15	1995	7.00 A M				
	The second of th	5. SEX 6. AGE (In y)	rs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAR 29	932	RTHPLACE (State or Foreign untry)				
	9e. FACILITY HAME (If not institution, give stre			9b, CITY, TOWN	OR LOCATION OF DE		9c. COUNTY O	MD F DEATH				
S S	593 Orchard Stre	et			imore			N/A				
נו	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		100 CIT	Y, TOWN OR LOCA	71011							
DIRECTOR	Md N/	A		timore	illon			10d. INSIDE CITY LIMITS?  1 XYES 2 NO				
	10e. STREET AND NUMBER			1	M. ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?				
FUNERAL		Т			21201		U S	S A				
F	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U.S FORCES? 1 TYPES 2	NO NO	13. WAS DE	CEHDENT OF HISPAN Decify Cuban, Mexica	HC ORIGIN? (Specify Yes	or No- 14, R	ACE — American Indian, lack, White, etc.				
3 Wildowed 4 Divorced IF YES, OIVE WAR OR DATES 1 YES 2 NO Specify: Specify:												
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	(TION 18-		USUAL OCCUPAT		16b. KIHD OF BUS	SINESS/IHDUSTR	Black				
9	Elementary/Secondary (0-12)	College (1-4 or 5+) N / A	life. Do NOT us	e retired.)	osi ui worung							
AM	17. FATHER'S HAME (First, Middle, Last)	N/A	CLERE		Les MOTUERIS MA		STORE	2				
TO BE	19e. IHFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural I	Soute Number, City or Tow						
F	JEROME THOMPSO	ON JR.	41	S MOI	RLEY ST	BALTO,	MD 212	229				
	20e. METHOD OF DISPOSITION  X X Burlel 2 Cremation 3 Remov	rel from State 20b. PLi	ACE AND DATE O	EMORIAL	ame of	1	CATION — City o					
	4 Donation 5 Other (Specify)		ING MI	22. HAME A	ND ADDRESS OF FA	6209\$ RA	NDALLS	STOWN, Md				
	Mus. B	100		Mar	ch F/H We	st	2					
$\dashv$	23. PART I. Enter the diseases, or co	mplications that caused th	e death. Do n	430		Avenue Ba	ltimore	e, Md 21215				
	ahock, orbeert fallure. LI IMMEDIATE CAUSE (Fine)	at only one ceuse on each	line.					Approximate interval Setween Onset and Death				
	disease or condition											
	DUE TO (OR AS A CONSEQUENCE OF);											
NO	DIE MO ME AC A COMPEQUENCE OF											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING											
E	CAUSE (Disease or Injury that Initiated events pauling in death) LAST											
EH	d.											
	PART II. Other algnificent conditions	contributing to deeth but r	not resulting i	n the underlyir	g ceuse given in	Pert I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO				
MEDICAL						1 _ YES 2		COMPLETION DF CAUSE OF DEATH?				
M	DID TORACCO LICE CONTRI	DUTE TO CAUSE OF T	SEATH ME		7			1 - YES 2 - NO				
PHYSICIAN:	DID TOBACCO USE CONTRI			H (Check only one	UNCERTAIN	1						
SIC	EXAMINER?	HOSPITAL:		OTHER:	ne 5 NRaeldence	B Other (Speaks)						
높	27. MANHER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 26c. IN	JURY AT DRK?	28d. DESCRIBE HOW II	JURY OCCURED					
Β¥	1 M Hatural 5 Pending Investigation			M 1 🗆	YES 2 HO							
	3 Suicide 6 Could not be 4 Homicide datermined	28s. PLACE OF INJURY — A building, atc. (Specify)	At home, farm, si	11		281. LOCATIOH (Street a City or Town, State)	nd Number or Rur	al Route Number,				
Significant of the design of t												
MP		On the best of my knowledge On the bests of examination and						e(a) and manner as stated				
	296. SIGNATURE AND TITLE OF CENTIFIER	100	.10		29c, LICEHSE HUM		29d. DATE SIGN					
) BE	Ah-L. Hay	Heater 1)	MEL		DO	2031	D 6	-16-95				
유	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type,		P.P.	Rema	do	f-21216				
	31. DATE FILED (Mogth, Day, Mar)	12. PEGISTIPAR'S SMATU	) , )	8-31	opar	grove.	STID	21-61616				
	JUN 2 I 1995	pa diministration	all		•	V						



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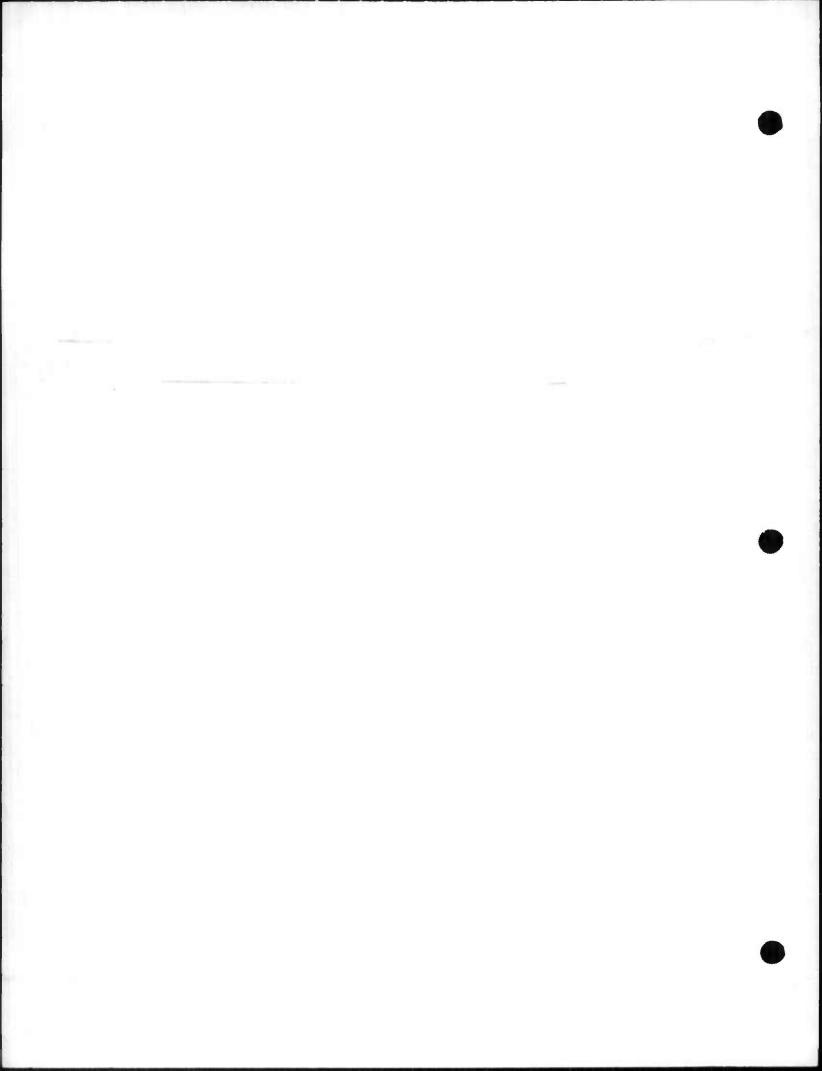
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	Middle Lest)									0.0475	OF DEATH		T		
		Bette Le	eah		VOSS:	LER						MONTH		995	YEAR	3. TIME OF DEATH 8:00P	
		4. SOCIAL SECURITY NUMB		5. SEX		In yrs. last	birthday)	IF UNDER		IF UNDER	9 24 HRS.	7. DATE C	OF BIRTH		B. BIRTHE	PLACE (State or Foreign	
pin		217 34 9834	- Ab- al	1 🗆 M 2 💢 F		56	YRS.	MONTHS	DAYS	HOURS	MIN.	July	15,19		Mary.	land	
3 should	œ	9a. FACILITY NAME (If not in			9b. CITY, TOWN					ON OF DE	EATH			ITY OF DE			
1, 2,	DIRECTOR	Franklin So	MOTE L	ospitai	cent	er		Ro	SSV	ille				ва.	Ltimo	ore	
Pages	E	10a. STATE	10b. COUNTY				10c. CIT	Y, TOWN (								10d. INSIDE CITY LIMITS?	
J.		Maryland 100. STREET AND NUMBER	Balti	more				Dur	ndal		_					1 YES 2 NO	
physician. burial-transit permit. Pages	FUNERAL	407 Trappe	Road						10	or. ZIP COD	222					HAT COUNTRY?	
sician.	S	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN	U.S. ARM	MED			CENDENT C	OF HISPAN		U.S. GIN7 (Specify Yea or No.— 14. RACE			- American Indian	
attending physician. se as the burial-trai	ВУ Б	1 Never Married 2 3 3 Widowed 4 Divo		FORCES? 1	WAR OR DA	ATES XING	0			B 2 3 NO			icen, etc.)		Specify		
attendi		18. DEC	EDENT'S EDUC	CATION		18e. DEC	EDENT'S	USUAL O	CCUPATI	ION		16b.	KIND OF BUS	SINESS/IND	USTRY	White	
al or for u	COMPLETED	Elementary/Secondary (0	highest grade -12)	College (1-4 or 5	+)	(Gh	e kind of v Do NOT us	vork done e retired.)	during m	ost of workli	ng	TO THE OF SOURCESTING STATE					
2 2	MP	12				Flo	ral	Desi	gne	r			Florist				
de de		17. FATHER'S NAME (First, Mi		h						THE PERSON			iddle, Maiden				
	BE	Leon Charle		hnson		195	Marie Zilinski  19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	2	Deborah Ann											, Mar			21	
> 0 0	20a. METHOD OF DISPOSITION 1   Burlai   2 St. Cremetton 3   Removal trom State 4   Donation 5   Other (Specify)   Green						MODATE	SE DISPOS	ITION (A)	ame of		DATE	20c. LO	CATION — C	Ity or Tow	Town, State	
Page 6 Il directo		4 Donation 5 Other  21. SIGNATURE OF FUNERAL		ENSEE	Gr	etery, crem	ount				6/19	7/199	5 Balt	imor	e, M	aryland	
death. Pag tuneral di 1. examiner								22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A.						•			
n by the fi removal.		h .	- 1-2	<u>سمي</u>	_			14	07	Easte	ern A	lve.	Baltir	nore,	Mar	yland 21221	
d in to		shock, or he	est Isnure.	omplications the list only one cau	ise on er	ch line.	ith. Do n	iot enter	the mo	ode of dy	ing, sucl	h 88 cardi	ec or respi	ratory sm	est,	Approximate interval Between Onset and Death	
		disesse or condition resulting in desth)		Respir	atory	y fa:	ilur	e								2hours	
B 2 7 9			DUE TO (OR AS A CONS Metastatic br														
and and parti	ON	Sequentielly list condition			OR AS A				er							3years	
ysician prior p	CAT	if sny, lesding to immed cause. Enter UNDERLY!	NG		(0	00//020	DEMOE OF	,									
he death certificate be the attending physician Mental Hygiene prior to hjury, or other traus	CERTIFICATION	CAUSE (Disease or injust that initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSECU	SEQUENCE OF):										
attendi rtal Hy y, or	ER	resulting in destri) CAS															
quires that the death signed by the atter Health and Mental ows any Injury, o		PART II. Other significal	nt condition	contributing to	deeth be	ut not re	suiting i	n the un	derlyin	g ceuse g	given in	Pert I.	24a, WAS AN PERFOR			WERE AUTOPSY FINDINGS	
signed by Health ar	MEDICAL												1 TES 2			MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
requires been sign of Heath	- 1	DID TODA 660 III						_								1   YES 2   NO	
law as b bept	AN	DID TOBACCO US		IRUIE TO CA		F DEAT					ERTAIN	1 🗆 📗					
OR ATTENDING PHYSICIAN: The law required DIRECTOR: After this certificate has been rours after death with the State Dept. of Item 28 is marked, or Item 23 sho	PHYSICIAN:	EXAMINER?		HOSPITAL:				OTHER	l:	ne 5 🗆 Re	aldence	6 Other	(Specify)				
YSICIA s certif th the	눚	27. MANNER OF DEATH		28e. DATE OF (Month, D	INJURY		26b. TIMI	E OF	28c. IN.	JURY AT	T T		RIBE HOW IN	JURY OCC	URED		
After this of death with s marked,	ВУ		Pending nvestigation	(Morali, D	ay, roar)		ING	M		YES 2	ON						
OR ATTENDING DIRECTOR: After hours after death Item 28 is ma	9		Could not be	28e. PLACE O building,	F INJURY etc. (Speci	— At hom	e, ferm, s	treet, tect	ory, offic	:0		281. LOCA City or	TION (Street e Town, State)	nd Number (	or Rural Ro	ute Number,	
OR AT DIRECT hours a item 2		20- CERTIFIER															
7 70 -	COMPLET	(Check only		CIAN: To the best of R: On the basis of a												and manner as stated.	
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: I	ш	296. SIGNATURE ANDNITLE	OF CERTIFIER							29c. LICE	NSE NUM	BER		29d. DATE	SIONED (	Month, Day, Year)	
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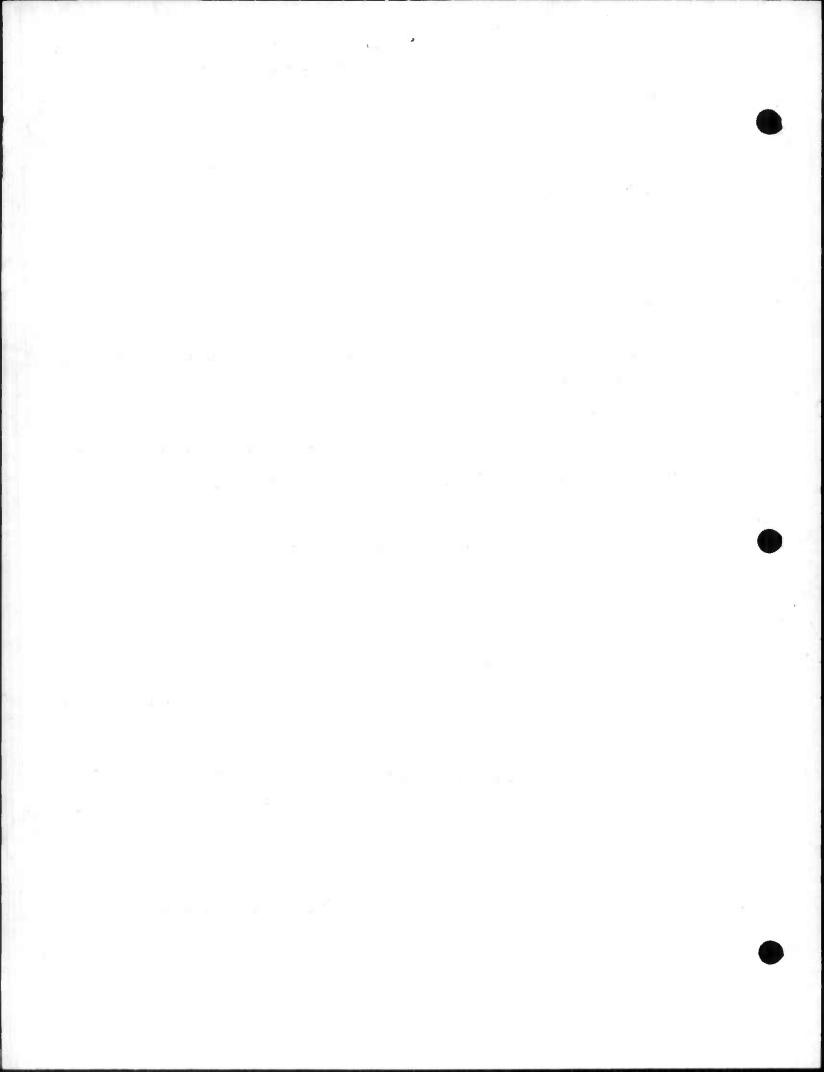
		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL	HYGIENE REG. NO.			
	3	1. DECEDENT'S NAME (First, Middle, La	Winkler	,			2. DATE MONTH		XE!	10	TIME OF DEATH
pin		4. SOCIAL SECURITY NUMBER 230-56-2630	1 - M 2 - F	(In yrs. last birthday) 59 YRS.	MONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	7. DATE (Month	OF BIRTH , Day, Ybar)	8. B	IRTNPLA ountry)	RGINIA
. 2, 3 should	TOR	SO. FACILITY NAME (If not institution, gited of the second section of the second secon				TIMORE			oc. county o		н
f. Pages 1	DIRECTOR	10a. STATE 10b. COU	N/A	10c, Cf	TY, TOWN OR LOCA	TIMORE	CITY	7		1111	d. INSIDE CITY LIMITS?
nsit permit.	FUNERAL	100. STREET AND NUMBER 1219 KITMORE	ROAD			1. ZIP CODE 21239				U.S.A.	
D D	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO If yes, specify Cuban, Maxican, Puerto Rican,					Ify Yes or No 14. RACE - American Inc		
	(FED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	G. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  SPRING FOOD SERVICE ASSISTANT  STATE HOSE						
y the hosp to detached at once.	CON	8TH  17. FATHER'S NAME (First, Middle, Last)  ALBERT F. S	N/a M SIMMONS	117 0			AME	-	TE HOSPITAL		
mished by 5 should b notified a	TO BE	19e. INFORMANT'S NAME (Type/Print)			G ADDRESS (Street I	and Number or Rural	l Route Numb	er, City or Town, S			utts
ne 6 may be in motor, page 5 must be n		WTT.T.TAM  20a. METHOD OF DISPOSITION  1X Buriel 2 Cremetion 3 R  4 Donation 5 Other (Specify)	TNKT.FR  20b gam GA	PLACE AND DATE	KITMOR OF DISPOSITION (NO Other Diace) FORES	ment C /O A	BAI CEM		IGS M		State S, MD.
ter death. Pag the tuneral di wal		21. BIGHARURE OF FUNERAL BERVICE		e, Shi	CAL	ND ADDRESS OF F VIN B. E. PRES	SCRU	IGGS FU	JNERA	L H	IOME
nted within 24 hours after completely filled in by fal, cremation, or amount event, the medical		23. PART i. Enter the diseases, part is shock, pr heart failured immediate CAUSE (Final disease or condition resulting in death)	e. List only one cause on a  a. MYUCAN)  DUE TO (OR AS A	ech line.	not enter the mo	de of dying, au	ch as card	lac or reapirate	ory arrest,		Approximate Interval Between Onset and Destr
th certificate be executed ending physician and corr I Hygiene prior to burlal, or other traumatic ex	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST  DIABETES MELLITIS  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  CHRANC Serve TWILLIE  S. DIABETES MELLITIS  DUE TO (OR AS A CONSEQUENCE OF):  S. DIABETES MELLITIS  S. DIABETES MELLITI									
that the ed by the h and Ma	MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPS PERFORMED?  1 YES 2 NO							07	AWA	RE AUTOPSY FINDINGS JLABLE PRIOR TO MPLETION OF CAUSE DEATH?
law request been of ept. of 23 she	IN: ME	DID TOBACCO USE CON	ITRIBUTE TO CAUSE O	F DEATH Y	ES NO	UNCERTAI	IN 🗆				YES 2 NO
The hate h	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outp		OTHER: 4   Nursing Hom	e 5 Residence	6 🗆 Other	(Specify)			
	ВУ РН	27. MANNER OF DEATN  1 Natural 5 Pending 2 Accident Investigation			M 1 .	PRK? YES 2 NO		CRIBE NOW INJU			
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 8 Could not be determined	building, are. (Spec	əliy)			City o	TION (Street and in Town, State)		ral Route	Number,
로로	COMPLET	(Check only one) 2 MEDICAL EXAM	YSICIAN: To the best of my knowliner: On the basis of examination							se(s) sno	d manner as stated.
TO THE HOSPI TO THE FUNER DE filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIF	el rue		D	D37902		29	DATE SIGN	PED (Mor	11th, Day, Year)
()		Michael P. Lill	y, M.D., Univ	of Md.	Hospita	1, 22 S.	. Gree	ene St.,	, Balt	ю.,	MD 21201
O/		JUN 21 199	35 Java al Resident	erhardell							



18801

Items23PartI,27,28a,b,c,d,e,f 6-23-95 FilmG724 W.H.Per Ocme
RATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATI	E OF	DEATH		REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF				3. TIME OF DEATH
- 1	JEFFREY LOUIS YO	JNG					JUNI	E 1 <sup>P4</sup>	7,19	95	0813 A
	4. SOCIAL SECURITY NUMBER 5. SEX		In yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7 DATE OF	BIOTH		a BIRTI	ADI ACE /State or Formion
	218-78-8376 1 🗚 2 🗆	F	35 YRS.	MONTHS	DAYS	HOURS MIN.	JUN18	195		Count	"BALTIMORE, M
OR	99. FACILITY NAME (If not institution, give street and number 1503 EAST LANVALE S					OR LOCATION OF DE			9c, COU	NTY OF D	n/a
ទួ	RESIDENCE OF DECEDENT  106. STATE  10b. COUNTY		20.00			Wor					
DIRECTOR	MARYLAND n/a		10c. CITY, TOWN OR LOCATION BALTIMORE								10d. INSIDE CITY LIMITS? XX YES 2 \( \square\) NO
FUNERAL	100. STREET AND NUMBER 2518 AISQUITH	STREET	ET 104. ZIP CODE 21218				10g. CITIZEN OF				WHAT COUNTRY? STATES
3	11. MARITAL STATUS 12 WAS DEC	FRENT EVER IN	III S ADMED	13	WAS DEC	ENDENT OF HISPAN	HC OBIGINS	Sanaihi Van			E — American Indian.
₽	1 Never Married 2 Married FORCES7 3 Widowed 4 Divorced IF YES, G	1 YES	DATES \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				in, Puerlo Rican, etc.) Bli				k, White, atc.
COMPLETED	15. DECEDENT'S EDUCATION		16a. DECEDENT'S	USUAL O	CCUPATIO	ON	16b. K	IND OF BUS	SINESS/INC	DUSTRY	
4	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5 +)	(Give kind of life, Do NOT u	work done se retired.)	during ma	st of working	0000				
희	10 TH -		J	ANITO	)R			CLEAN	ING	SEE	RVICES
ő	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Melden Surname)										
BE C	LOUIS YOUNG					ROI	MAINE	JACH	<b>KSON</b>		
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORES	S (Street e	1	mber or Rural Route Number, City or Tow			Code)	
일	ROMAINE NEAL		251					ET, BALTIMORE,			21218
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	-			DATE		CATION -		
1	X ☐ Burlel 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	ceme	RAL TIMO	other place)	EME.	TERV	6-23	1			
	Surfel 2   Cremation 3   Removal from State   Cemetery, crematory or other place									בין ויוט	
	S. Valencia	Vall	land	_	WM.	C. MARCH	H FH.	_110	l E.	NOF	RTH AVE.
	23. PART I. Enter the diseases, or complications shock, or heart fellure. List only one	thet caused	the deeth. Do	not enter	the mo	de of dying, sucl	h as cardia	c or reapi	ratory arr	reat,	Approximate
	IMMEDIATE CAUSE (Final	Cansa ou ee	ich line.								interval Between Onset and Death
Ì	disease or condition resulting in death)  Narcotic and Alcohol Intoxication										
İ			CONSEQUENCE C		11100	AICHEION					
z											
윤	Sequentially list conditions, If any, leading to immediate	E TO (OR AS A	CONSEQUENCE O	F):							
CERTIFICATION	CAUSE (Disease or injury										
<u> </u>	that initiated events	TO (OR AS A	CONSEQUENCE O	F):							
H	resulting in death) LAST										
	PART ii. Other aignificent conditions contributing	to deeth bu	it not resulting	in the un	dedvin	cours alves in	Dart I a	. 1000 001	ALITTORAN		
DICAL		g 10 000111 D0	At Hot readiting	iii tiie uii	Continu	cause given in	Paint I. 24	PERFOR		246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
							—   ¹	YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: ME				_							1, TYES 2 INO
ž I	DID TOBACCO USE CONTRIBUTE TO					UNCERTAIN	10				
ਠੋ∥	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL		86. PLACE OF OEA	OTHER							
<u>S</u>		2 ER/Outpe	ntient 3 🗆 DOA	4 🗆 Nun	ling Hom	• XX Residence	6 Other (S	(pecify)			
ᇤ	(Mor	E OF INJURY th, Day, Year)	26b. TIN	IE OF	28c. INJ WO	URY AT RK?	26d. DESCR		JURY OCC	CUREO	
à l	2 Accident	nd:6-17	7-95 7:3	4A M	1 🗌 1		Unkn	own			
	DUI	CE OF INJURY -	At home, ferm,	street, fact	ory, office		281, LOCATI	ON (Street e	nd Number	or Rural F	Route Number,
		ıse					1503	E . L	anva	le S	t.Balto,Md.
7	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the be	st of my knowle	edge, death occurr	ed at the ti	me, date	end place, end due	to the causei	e) end men	per ee stat	ad	
COMPLETED	One) MEDICAL EXAMINER: On the basis										end menner es stated.
Ŭ W	29b. SIQNATURE AND TITLE OF CERTIFIER	_				29c. LICENSE NUM					
10 CE		MD				O.C.M				UNE	(Month, Dey, Year) 18,1995
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED		TH (ITEM 27) (See	Print)		0,0,11			-		_0,
	DONALD G. WRIGHT MI				reet	t, Balt	imore	e, Ma	aryl	and	21201
		TRAR'S SIGNA				*					
	JUN 2 1 1995 Jalia Dave	Gor Rand	all								

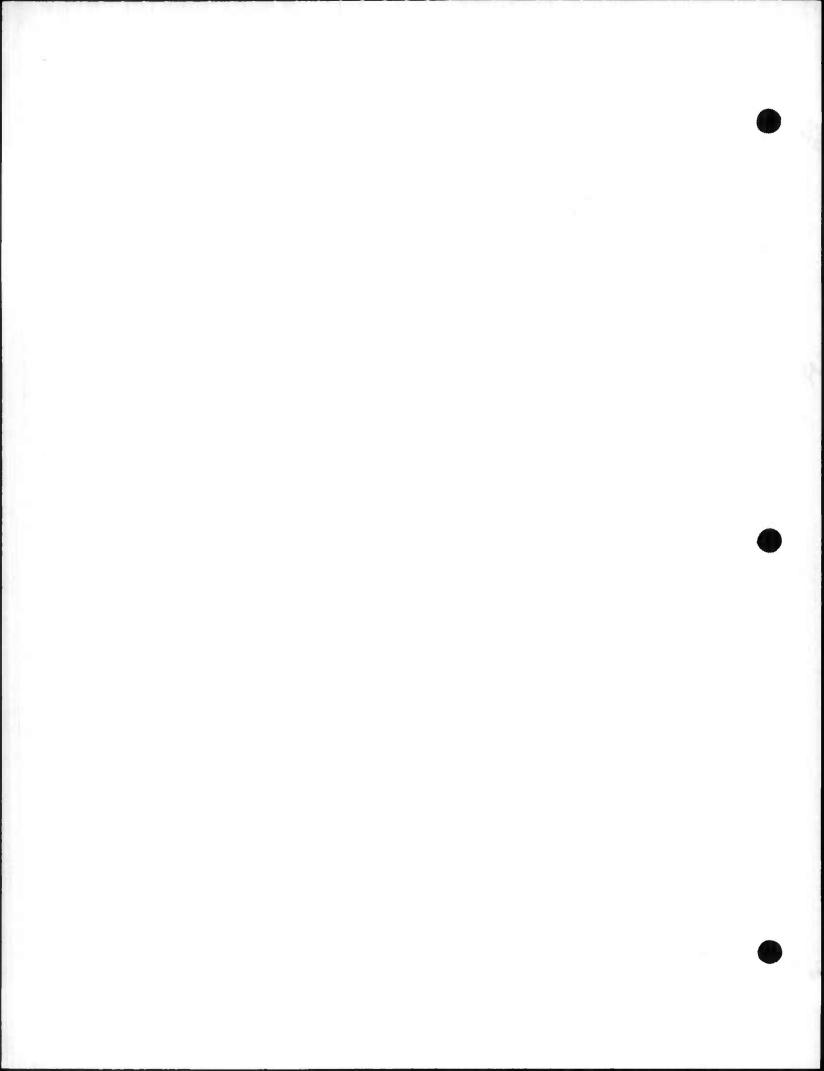


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.	sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should prior to burial, cremation, or removal.	ist be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral din be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	DEATH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			. TIME OF DEATH			
	George Edwar	d Young				June 17		EAR O G	7:30 a M			
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTNPL	ACE (State or Foreign			
	220 07 4352	13\( \) XM 2 \( \) F \( \) 8	9 YRS.	PONTHS DAYS	HOURS MIN.	(Month, Day, Year) March 15		Country)	Md.			
	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOWN C	OR LOCATION OF O		9c. COUNTY					
OR	Sykesville Eld	er Care Ce	nter	Sv	kesvill	٥	Carr	011				
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT			TOWN OR LOCAT			TOGIL					
IRI		altimore						1.0	Dd. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	altimore	Ba	altimo	T E				TES 2 X NO			
RA	3424 Gaither	Pond		100	1244		AT COUNTRY?					
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	NUS ARMED			NIC ORIGIN? (Specify Ye						
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If yes, sp	ecity Cuban, Maxico	n, Puarto Rican, etc.)	Black, V	- American Indian, Vhita, atc.				
BY	3 Widowed 4 Divorced	W 123, GIVE WAN ON DI	AI ES	I LI YES	2 The No Specif	у:	Specify:	k				
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION	16e. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working)  16b. KIND									
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	We Do NOT use with d									
MP	8	0	Truck	Drive	r	Monar	ch Fo	ods				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Meiden						
BE	Unknow											
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, Stete, Zip Co	de)				
		Young	3424 0	aither	r Rd. B	altimore	, Md.	21	244			
	20s. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION AND DATE OF DISPOSITION 20b PLACE AND DATE OF DAT											
	XIXBurial 2   Cremation 3   Removal from State   Commeter, Crematory or other place   St. Lukes Cemetery   Commeter   C											
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME AN	ID ADDRESS OF FA	aight Fu	noral	шо	m.o.			
	Harry 71.	Hought		P. 0.1		Sykesvi						
	23. PART I. Enter the diseases, or a	complications that caused List only one cause on e	the death. Do no	t enter the mo	de of dying, auc	h as cardiac or reap	Iratory arrest	i.	Approximate			
	IMMEDIATE CAUSE (Final	List only some cause on e	ecn line.						Interval Batween Onset and Death			
	disease or spediales											
	resulting in death)  a. Multi Talant De resta  Due to (or as a consequence of):											
z	Sequentially list conditions b.											
Ĕ	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):											
3	CAUSE (Disease or injury											
Ë I	that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
	reaulting in death) LAST	C. DUE TO (OR AS A	CONSEQUENCE OF):									
5		DUE TO (OR AS A	CONSEQUENCE OF):									
AL CERTIFICATION	resulting in death) LAST  PART II. Other aignificent condition	d	ut not resulting in		ceuse given in			24b. W	ERE AUTOPSY FINDINGS			
A	resulting in death) LAST  PART II. Other aignificent condition	d	ut not resulting in		g ceuse given in	PERFOR	MED?	AM CC	MILABLE PRIOR TO OMPLETION OF CAUSE			
A	reaulting in death) LAST	d	ut not resulting in		g ceuse given in		MED?	CC OF	BILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
A	resulting in death) LAST  PART II. Other aignificent condition	d	ut not resulting in	the underlying		PERFOR	MED?	CC OF	MILABLE PRIOR TO OMPLETION OF CAUSE			
A	PART II. Other aignificent condition Penal Coll Co	RIBUTE TO CAUSE O	ut not resulting in	the underlying  NO (Check offy one)		PERFOR	MED?	CC OF	BILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
A	PART II. Other algorificent condition  Penal Call Call  DID TOBACCO USE CONTI	ne contributing to deeth be	ut not resulting in	the underlying  NO  (Check off one)	UNCERTAI	PERFOR	MED?	CC OF	BILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
A	PART II. Other aignificent condition  Peral Call Ca  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp	ut not resulting in	the underlying  NO  (Check ofly one)  THER: Nursing Homo  OF 28c. INJU	UNCERTAIL  5 G Residence	PERFOR	NO NO	CC OF	BILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
PHYSICIAN: MEDICAL	PART II. Other aignificent condition  Peral Cell Ca  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH  1   Netural 5   Pending	RIBUTE TO CAUSE O	ut not resulting in	the underlying  NO (Check offy one)  THER: Nursing Homo  Y  WO  V  WO	UNCERTAIL  5 G Residence	PERFOR	NO NO	CC OF	BILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?			
BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  PENLL CUL/ Ca  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp	F DEATH YES  28. PLACE OF DEATN  28b. TIME  At home, farm, sto	the underlying  NO (Check offy one)  THER: Nursing Homo OF 28c. INJU	UNCERTAII  5 G Residence  JRY AT  RKY  ES 2 NO	PERFOR  1 YES 2  N	NJURY OCCUR	AM CC OF	MALABLE PRIOR TO MALABLE PRIOR TO DEATH? YES 2 NO			
BY PHYSICIAN: MEDICAL	PART II. Other algnificent condition  Paral Call Co  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp.  28e. DATE OF INJURY  28e. PLACE OF INJURY	F DEATH YES  28. PLACE OF DEATN  28b. TIME  At home, farm, sto	the underlying  NO (Check offy one)  THER: Nursing Homo OF 28c. INJU	UNCERTAII  5 G Residence  JRY AT  RKY  ES 2 NO	PERFOR 1 YES 2  N	NJURY OCCUR	AM CC OF	MALABLE PRIOR TO MALABLE PRIOR TO DEATH? YES 2 NO			
BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  PENAL CUL/ Co  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Spec	out not resulting in  F DEATH YES  28. PLACE OF DEATN  retient 3 DOA 4  28b. TIME INJUF	the underlying    NO	UNCERTAII  5 G Residence  JRY AT  RK7  ES 2 G NO	8 Other (Specify) 28d, DESCRIBE NOW I  28f, LOCATION (Street City or Town, Stete)	NJURY OCCUR	AM CC OF	MALABLE PRIOR TO MALABLE PRIOR TO DEATH? YES 2 NO			
BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  PENAL CUL/ Ca  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only) 1 CERTIFYING PNYSI	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp.  28e. DATE OF INJURY  28e. PLACE OF INJURY	out not resulting in  F DEATH YES  26. PLACE OF DEATN  retiant 3 DOA 4  26b. TIME INJUF  At home, farm, straffy)	the underlying    NO	UNCERTAII  5 Gradence  JRY AT  RK?  ES 2 NO  and place, and due	8 Other (Specify) 28d, DESCRIBE NOW I City or Town, Stete) to the couse(s) and mai	NJURY OCCUR	AW CC OF 1 1	ALABLE PRIOR TO MPLETION OF CAUSE TOEATH? YES 2 NO			
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  PENAL CUL/ Ca  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only) 1 CERTIFYING PNYSI	RIBUTE TO CAUSE O  RIBUTE TO CAUSE O  HOSPITAL: 1   Inpatiant 2   ER/Outp  28e, DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge)  CIAN: To the best of examination	out not resulting in  F DEATH YES  26. PLACE OF DEATN  retiant 3 DOA 4  26b. TIME INJUF  At home, farm, straffy)	the underlying    NO	UNCERTAII  5 Gradence  JRY AT  RK?  ES 2 NO  and place, and due	8 Other (Specify) 28d, DESCRIBE NOW I  28f, LOCATION (Street City or Town, Stete) to the cause(s) and mai	NJURY OCCUR	ED  Rural Route	PALABLE PRIOR TO  MPLETION OF CAUSE  DEATH?  YES 2 NO  No Number,  No Number,			
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  Penal Call Call  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   Yes 2   NO  27. MANNER OF DEATH  1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined  29. CERTIFIER (Check only one)  2   MEDICAL EXAMINE	RIBUTE TO CAUSE O  RIBUTE TO CAUSE O  HOSPITAL: 1   Inpatiant 2   ER/Outp  28e, DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge)  CIAN: To the best of examination	out not resulting in  F DEATH YES  26. PLACE OF DEATN  retiant 3 DOA 4  26b. TIME INJUF  At home, farm, straffy)	the underlying    NO	UNCERTAIL  5 G Residence  JRY AT  RK?  ES 2 NO  and place, and due  asth occured at the	8 Other (Specify) 28d, DESCRIBE NOW I 28f, LOCATION (Street City or Town, Stete) to the cause(s) and mai time, data and place, en	NJURY OCCUR	ED  Rural Route	ALABLE PRIOR TO MPLETION OF CAUSE TOEATH? YES 2 NO			
COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  Penal Call Call  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   Yes 2   NO  27. MANNER OF DEATH  1   Natural 5   Pending Investigation 3   Suicide 6   Could not be determined  29. CERTIFIER (Check only one)  2   MEDICAL EXAMINE	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge)  ICIAN: To the best of my knowledge. On the basis of examination	ut not resulting in  F DEATH YES  28. PLACE OF DEATN  retient 3 DOA 4  26b. TIME  INJUF  At home, farm, structify)  At home, farm, structify)  At home, farm, structify  At home, farm, structify  At home, farm, structify  ATN (ITEM 27) (Type, P.	the underlying    NO	UNCERTAIL  5 GRaddence  JRY AT  RK7  ES 2 NO  and place, and due  and place, and due  and place and due  29c. LICENSE NUE	8 Other (Specify) 28d, DESCRIBE NOW I 28f, LOCATION (Street City or Town, Stete) to the cause(s) and mai time, data and place, en	NJURY OCCUR	ED  Rural Route	PALABLE PRIOR TO  MPLETION OF CAUSE  DEATH?  YES 2 NO  No Number,  No Number,			
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other algnificent condition  Paral Call Call  DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge)  ICIAN: To the best of my knowledge. On the basis of examination	ut not resulting in  F DEATH YES  28. PLACE OF DEATN  retient 3 DOA 4  26b. TIME  INJUF  At home, farm, structify)  At home, farm, structify)  At home, farm, structify  At home, farm, structify  At home, farm, structify  ATN (ITEM 27) (Type, P.	the underlying    NO	UNCERTAIL  5 GRaddence  JRY AT  RK7  ES 2 NO  and place, and due  and place, and due  and place and due  29c. LICENSE NUE	8 Other (Specify) 28d, DESCRIBE NOW I 28f, LOCATION (Street City or Town, Stete) to the cause(s) and mai time, data and place, en	NJURY OCCUR	ED  Rural Route	PALABLE PRIOR TO  MPLETION OF CAUSE  DEATH?  YES 2 NO  No Number,  No Number,			
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other aignificent condition  Penal Call Co  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 Ves 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  20. CERTIFIER (Check only One) 2 MEDICAL EXAMINE  29b. SIGNATURE AND TITLE OF CERTIFIER	RIBUTE TO CAUSE O  RIBUTE TO CAUSE O  HOSPITAL: 1   Inpetiant 2   ER/Outp  28e. DATE OF INJURY (Month, Day, Year)  28a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge)  ER: On the best of examination  R  O COMPLETED CAUSE OF DEF	ut not resulting in  F DEATH YES  28. PLACE OF DEATN  retient 3 DOA 4  26b. TIME  INJUF  At home, farm, structify)  At home, farm, structify)  At home, farm, structify  At home, farm, structify  At home, farm, structify  ATN (ITEM 27) (Type, P.	the underlying    NO	UNCERTAIL  5 GRaddence  JRY AT  RK7  ES 2 NO  and place, and due  and place, and due  and place and due  29c. LICENSE NUE	8 Other (Specify) 28d, DESCRIBE NOW I 28f, LOCATION (Street City or Town, Stete) to the cause(s) and mai time, data and place, en	NJURY OCCUR	ED  Rural Route	PALABLE PRIOR TO  MPLETION OF CAUSE  DEATH?  YES 2 NO  No Number,  No Number,			



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Panes 1.2.3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or Hem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deat	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the atte	be filed within 72 hours after death with the State Dept. of Health and Mental	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury,

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3	. TIME OF DE	ATN
	Martin	ZE	NTZ			June 19,1		AR	3:50	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.1	BIRTHPL	ACE (State or	Foreign
	215-03-0731	1½ M 2 □ F 8	34 YRS. "	IONTHE DAYS	HOURS MIN.	(Month, Day, Year) 4-24-11		Country)	Md	
	Se. FACILITY NAME (If not institution, give a			9b. CITY, TOWN I	R LOCATION OF DE		9c. COUNTY			
OR	Franklin Squa	re Hospital		F	ossville		Balti	timore		
ਹ	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT									
DIRECTOR	MD NO. COUNT	Baltimore	10c. CITY,							
	10e. STREET AND NUMBER	Dartimore				1 TYES 2 NO				
RA	8620 Kelso Dr. A	Dt. D312			10g. CITIZEN OF W USA					
FUNERAL	11. MARITAL STATUS				21221			SA		
	1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 😿 NO	13. WAS DEC	ENDENT OF NISPAN Icify Cuban, Maxical	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	s or No- 14.	RACE - Black, V	- American in White, atc.	dian,
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES 1	1 TYES	2 NO Specify	<i>r</i> :		Specify:	wh	ite
	15. DECEDENT'S EDU	CATION	16e. DECEDENT'S U	SUAL OCCUPATION	N .	16b. KIND OF BU	SINESS/INDUST	BV		
	(Specify only highest grade Elementary/Secondary (0-12)	Cottege (1-4 or 5 +)	(Give kind of wo	rk done durina ma	st of working					
COMPLETED	8	0	Truc	k Drive	r	Tru	cking			
Ŏ.	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NAI	ME (First, Middle, Maiden				
H	George Zentz				(unk	.)				
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	OORESS (Street a	nd Number or Flural F	Route Number, City or Tow	n, State, Zip Coo	0)		
ا ۴	Laura I. Zentz		8620	Kelso D	r. Apt.	D312, Esse	x, Md	212	221	
	20a, METNOD OF DISPOSITION 1√ Burlel 2 ☐ Cremation 3 ☐ Ram		PLACE AND DATE OF			DATE 20c. LO	CATION — City	ty or Town, State		
	1 ☐ Suriel 2 ☐ Cremation 3 ☐ Ram 4 ☐ Donation 5 ☐ Other (Specify)		Blue Ridg	2-95 T	hurmon	t, N	1d			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			D ADDRESS OF FAC	CILITY				
	) mis	X. Kellin		dale Funer aco Ave.	al Home					
	23. PART i. Enter the diseases, or o	compilections that course	the deeth. Do not	t enter the mo	de of dying, auch	n as cardiac or read	ratory arrest		Approxi	mete
	shock, or heart fallure.  iMMEDIATE CAUSE (Final	List only one cause on e	ach line.				,		Interval	Between
	disease or condition								1	nd Death
	reaulting in death)		CONSEQUENCE OF):		ease				4yea	rs
2		h	S A CONSEQUENCE OF):						İ	
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A								
5	CAUSE (Disease or Injury	c								
HIFICATION	that initiated events resulting in death) LAST	OUE TO (DR AS A	CONSEQUENCE OF):							
		d								
A L	PART II. Other aignificent condition	a contributing to deeth b	ut not resulting in	the underlying	cause given in i	Part i. 24s. WAS AN	i. 24a. WAS AN AUTOPSY			FINDINGS
	Renal failure					PERFOR			MILABLE PRIO	
						1 TYES 2	X		F DEATH?	
-	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YES	Пиог	UNCERTAIN			,	YES 2	NO
HTSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTOERITAIN.	· La				
2	EXAMINER?	HOSPITAL: 1XX Inpatient 2 ☐ ER/Outp		THER:	5 Residence	6 Other (Specify)				
	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (	OF 28c. INJ	JRY AT	28d. OEŞCRIBE HOW II	NJURY OCCURE	D		
	1 Netural 5 Pending 2 Accident Investigation	(MORRI, Day, rear)	INJUR		ES 2 ND					
	3 Suicide 8 Could not be	28a. PLACE DF INJURY building, etc. (Spec	— At home, farm, stre	et, factory, office		281. LOCATION (Street a City or Town, Stete)	and Number or A	ural Flout	te Number,	
COMPLETED	4 Nomicide determined					City or lown, Stelle)				
ž 1	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	ledge, death occurred	at the time, date	and place, and due	to the cause(a) and man	ner sa stated.			
5	079) 2 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigation,	in my opinion, de	ath occured at the I	lime, data and place, an	d due to the cer	180(8) ar	nd manner ae	stated.
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM		29d. DATE SIG			
	Heary H.	Myint 1	MD.		R D 174					
2	30. NAME AND ADDRESS OF PERSON WHI	COMPLETEO CAUSE DF DE	ATH (ITEM 27) (Type, Pr	rint)	к и 1/4.		June	: 15	, 199	)
	Dr. Htay Myint 900	00 Franklin	Square Dr.	. Balti	nore, Man	ryland 212	37			
	31. DATE FILED (Month, Day, Year)	32. HEGISTHAR'S SU			-	-				
	JUN 2 1 1995	THE PURE PROPERTY	-							

It	em20b,c,Fi1m724,6/22/95,1t					95	10004		
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last)  TONA THAN AUSB	4,	SR		2. DATE OF DEATH MONTH DO	0,10	S. TIME OF DEATH		
	232-30-3072 1໘M2□F 7		F UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 3-27-23		BIRTHPLACE (State or Foreign Country)		
TOR	9a. FACILITY NAME (If not institution, give street and number)  North Aronale Hospital	9	1	OVINGE		Ahy	Aundel		
DIRECTOR	MD Anne Arundel Glen Burnie								
FUNERAL	106. STREET AND NUMBER 7355 Furnace Branch Rd.				21060 USA				
BY	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 Mio IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell file) yes, apecify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2本学的 Specify:					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)  1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	Give kind of work	k done during mos etired.)	st of working	18b. KIND OF BUS		TRY		
BE COM	11th Factory Worker FActory  17. FATHER'S NAME (First, Middle, Last)  Albert Ausby  Lene Clanton					OLY			
TO B	19m. INFORMANT'S NAME (Type/Print)  Jonathan Ausby, Jr.				Annapo				
	20s. METHOD OF DISPOSITION  1 Constitute of Company of Control of								
	21. SPONTUNE OF FUNERAL SERVICE LICENSEE	S A. MC	orton & S	Sons :	Funeral Homes				
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felture. List only one cause on each line.  Approximate interval Between Onset and Death disease or condition resulting in death)  a. Sep5/5/5								
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DEF TO (OR AS A CONSEQUENCE OF):    Week								
PHYSICIAN: MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO								
CIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  25. WAS CASE REFERRED TO MEDICAL  26. PLACE OF DEATH (Check only one)  EXAMINER?  OTHER:								
PHYS	1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify)  27. MANNEB F DEATH  28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORDS:								
red BY	2 Accident Investigation	8 Could not be  28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  City or Term State)					Rural Route Number,		
COMPLET	29s. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.								
TO BE CO	295 GONATURE AND TITLE OF CERTIFIER Van H. Schullfelen N	10		DZ8	221	29d, DATE SI	GNED (Morith, Day, Year)  NE 70 199		
	DAN IT, SCHARISCEDER, M	301 /	tespiTA	L Drive	L. Glen Bur	INIE, 1	Marycomp		
	31. DATE FILED (NOT) P2 1095 32 JESTEN S SIGNATUR	Harlett				- /	21061		

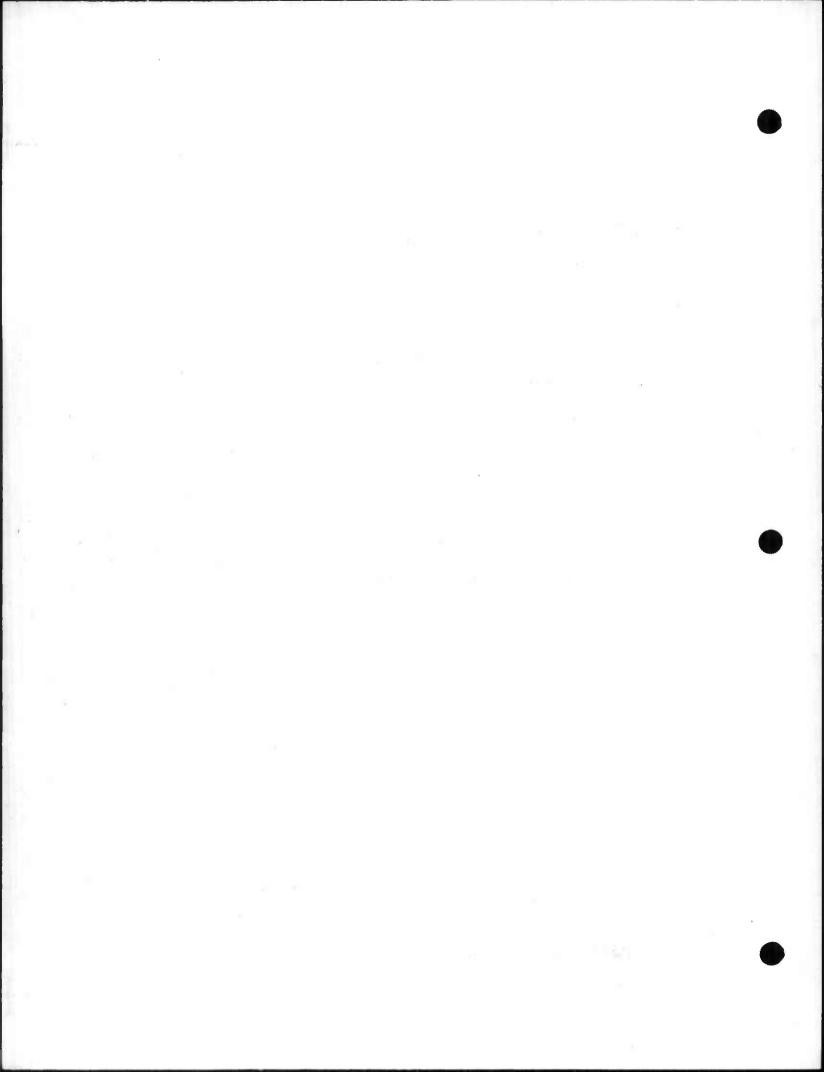
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	Pages	
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shx filled within 72 hours after death with the State Deot, of Health and Mental Horiene orior to burial, cremation, or removal.	- NO I

	1 - FOR STATE OF MAR	YLAND / DEPARTI CERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		
FUNERAL DIRECTOR	Myrtle M. Ackerman				June 21	1995	6:30 A. M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. A		ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	April 18,19	8. BIRTH		
	9e. FACILITY NAME (If not institution, give street end number)		b. CITY, TOWN C	R LOCATION OF DE		900 MG	aryland	
	Wesley Home Inc.	Wesley Home Inc. Baltimore						
REC	10e. STATE 10b. COUNTY						10d. INSIDE CITY LIMITS?	
0	Maryland N/A	A Baltimore				1 X YES 2 NO		
RAI	4301 White Ave. 21206				8	10g. CITIZEN OF Y		
N N				21206 ENDENT OF HISPAN	U.S.			
B≺	1 Never Married 2 Merried FORCES? 1 YES 2 NO If yes, specify Cu				Cuban, Mexican, Puerto Rican, atc.) Black, White, atc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  [Give kind of work done during most of working life. Do NOT use retired.]				16b. KINO OF BUSIN	ESS/INDUSTRY		
J.	Elementary/Secondary (0-12) College (1-4 or 5 +) UNKNOWN	1			0			
OM	17. FATHER'S NAME (First, Middle, Last)	Homemak	.er	Own Home  18. MOTHER'S NAME (First, Middle, Maiden Surname)				
BE C	John C. Vollmann	To. MOTHER O						
9 P	19e. INFORMANT'S NAME (Type/Print)							
-	Mrs Dorothy Aycock	Same	as 10e					
	26e. METHOD OF DISPOSITION  1 X Burlel 2 Cremetion 3 Removal from State  4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF Commenterly, cremeterly or other	DISPOSITION (Na DISPOSITION (Na DISPOSITION (Na	Park 6/	OATE 20c. LOCA	TION — City or To	wn, State	
1	1X Burlet 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) MOY Cland Memorial Park 6/23/95 Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc.							
	* Korald & Schol for		5305	Harford	l Road - Bal	timore	Inc. , Md. 21214	
PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or conflictions that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abook, or heart fellure. List only one cause on each line.    Approximate interval Between Onset and Death							
	PART II. Other algorificant conditions contributing to deat				1 YES 2	D?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check poly ope)							
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES   2   NO							
	7. MANNER OF DEATH  26e. DATE OF INJURY (Month, Dey, Year)  28c. INJURY AT WORK?  28d. DESCRIBE HOW INJURY OCCUREO  1 J YES 2 NO							
TED BY	2 Accident Investigation 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, larm, street, factory, office building, stc. (Specify)  28e. PLACE OF INJURY — At home, larm, street, factory, office City or Town, State)					loute Number,		
COMPLET	29s. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  Discretely independent on the cause (s) and manner as stated.  MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.							
BE	296. SIGNATURE AND TITLE OF CERTIFIER  Robert Flority, Mar.  296. LICENSE NUMBER  286. DATE SIGNED (Month, Day, Year)  6-21-95							
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
	Robert T. Liberto M.D. 3508 Bank Street - Balto. Md. 21231							
	31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SI	GNATURE			-	1		
	100 2 2 1995 Ali Ma	the Robert						





DHMH-16 Rev 1/89

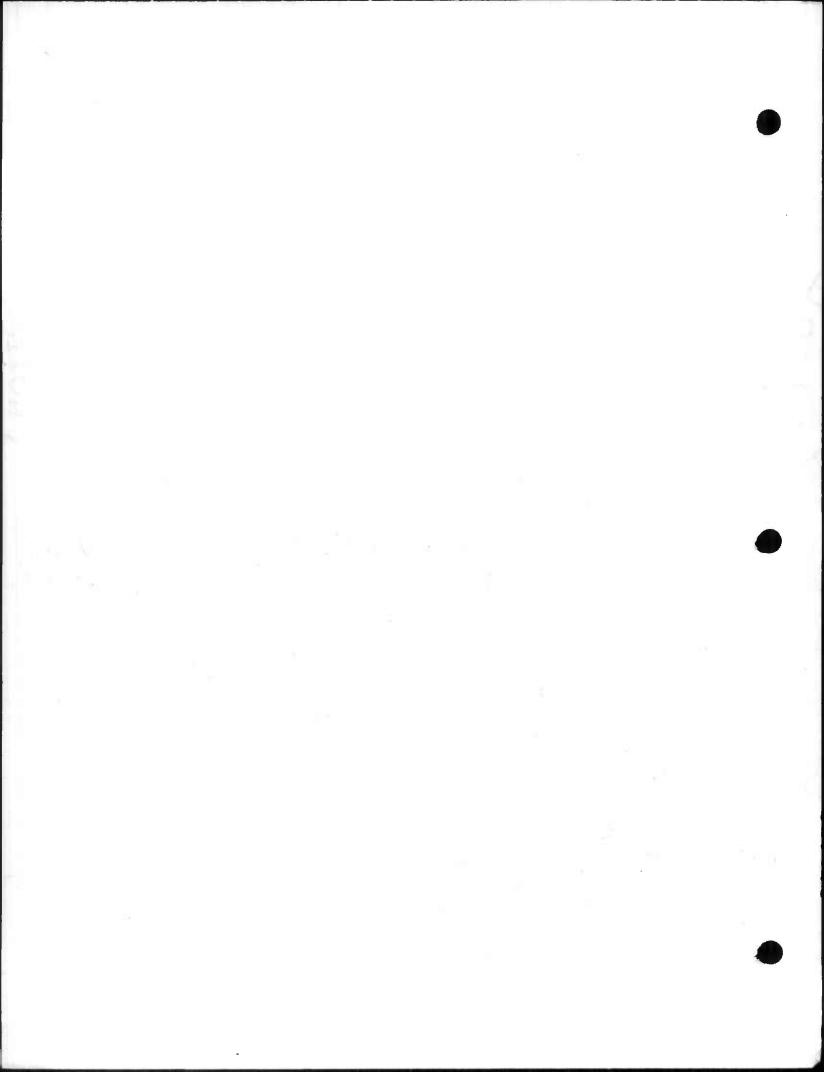
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be stressed to the state Dect. of Health and Mental Hydiene prior to hurial cremation or remand.	, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the further filled with the State Dent, of Health and Mental Hydiene prior in burfall cremation or removal	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.									
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	VICTORIA	М.	RRIEH		JUNE 18,	1995	10:57 P M			
	4. SOCIAL SECURITY NUMBER	77	140	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign		
	279-24-3946		69 YRS.			05-05-1926 OHIO				
Œ		9a. FACILITY NAME (If not institution, give street and number)  THE JOHNS HOPKINS HOSPITAL  BA					9c. COUNTY OF			
5	RESIDENCE OF DECEDENT	INS HUSPITAL		BALTIM	ORE CITY		N,	/A		
DIRECTOR	10a. STATE 10b. COUNT			OWN OR LOCAT				10d, INSIDE CITY		
					Έ			1 X YES 2 NO		
FUNERAL	10. STREET AND NUMBER				ZIP CODE			WHAT COUNTRY?		
NE	13150 CAROLINE COURT  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED				53122	U.S.				
	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			If yes, spe	cify Cuban, Mexica	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	E — American Indian, ik, Whita, etc.			
ВУ				1 U YES	2 NO Specify	Spec	WHITE			
LED	15. DECEDENT'S EDU (Specify only highest grade	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most				ON 166 KIND OF BUSINESS/INDUSTRY				
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work done during most of working life. Do NOT use retired.)							
COMPLET	1.2 17. FATNER'S NAME (First, Middle, Last)	4	. Itoria mikak							
S	NIHOM J. ABR	ΔΗΔΜ				ME (First, Middle, Maiden	,			
BE	19a. INFORMANT'S NAME (Type/Print)	AHI WI	19b, MAILING ADI	PRESS (Street at		NURA AWA]				
5	MARSHALL ARRICH					ELM GROVI		1122		
	20a, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem		PLACE AND DATE OF D	SPOSITION (Na			CATION - City or T			
	4 🖺 Donation 5 🗆 Other (Specify)	S	etery, cremetory or other p		RY 06-2	23-95 W	ARREN OH			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSE			T NC A CUT	ON FUNERAL		INC		
	Mully X	Haile				AVE., BA				
	23. PART I. Enter the diseases, or o	complications that caused List only one cause on ea	the death. Do not e	enter the mod	le of dying, such	as cardiac or reap	iratory erreat,	Approximate		
	MAMERIATE CALISE (Single									
	disease or condition resulting in death) Sepsis with Fungus Iwk									
	disease or condition resulting in death)  Sepsis with Fungus  Luk  Sequentially list conditions.  Sequentially list conditions.									
S	Sequentially list conditions, if any, leading to immediate DUILTO (OR AS A CONSCOURNCE OF):									
S	cause. Enter UNDERLYING CAUSE (Disease or injury									
E	that initiated eventa resulting in death) LAST	ed eventa DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	d.									
AL (	PART II. Other algorificant conditions contributing to death but not reculting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY FINDINGS									
	PERFORMED?  AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
WE								1 TES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
S S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF DEATH (C	heck only one)						
14S	1 YES 2 NO 27. MANNER OF DEATN	1 Inpetient 2 ER/Outps  a. DATE OF INJURY	11 DOA 4 DOA 4 D	Nursing Nome 28c, INJU	5 Residence	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Netural 5 Pending	(Month, Day, Year)	INJURY	WOR		28d. DESCRIBE HOW I	NJUHY OCCUREO			
Э ВУ	2 Recident Investigation 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, Ierm, street, I							et and Number or Rural Route Number,		
Ĭ	4 Nomicide detarmined	hullding mtc (Spacify)					City or Town, State)			
7	29a. CERTIFIER (Check only  CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated.									
COMPLETED	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner as stated.									
BEC	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)						(Month, Day, Year)			
10 B	QXI.	(H)			M5	208	Mun	e 19 1995		
-	30 NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE OF OEA	11 -	1 //	11	11111	11	- 1/1		
	31. DATE FILEO (Month, Day, Year)	32. REGISTIAN'S SIGNA	US TOSK	ITAL	660	N. Wolfe	- Dreot	Derlange		
	JUN 2 2 1995	1	•							
				_						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						10/11/2	<u> </u>	DEATH		HEG. NO.			
	,	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	F DEATH DA	4.0	YEAR	3. TIME OF DEATH
	- 1	Francis Patrick Brady Jr. June 19, 1995 7:30 A											
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR							7. DATE OF	7. DATE OF BIRTH 6. BIRTHPLACE (State or Fort			
	1	028-24-5099	CRAL SECURITY NUMBER   5. SEX   6. AGE (In yrs. leat birthday)   F. UNDER 1 YEAR   F. UNDER 24 HRS.   7. DATE OF BIRTIN   6. BIRTIN   6. BIRTIN   7. DATE OF BIRTIN							MASS	ACHUSETTS		
	œ												EATH
	DIRECTOR	265 Scotts Manor Drive Glen Burnie Anne Ar										rundel	
	입	SO STATE SO COUNTY											
	<u>=</u>	INC. GTT, TOWN ON EXCENTION									10d. INSIDE CITY LIMITS?		
		A. STREET AND MUNICIPAL CO.										1 YES 2 NO	
	M	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA										THAT COUNTRY?	
		265 Scotts Manor Drive 21061 United St										States	
	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14, RACE -										- American Indian,	
		1 Never Married 2 Married	IF YES, GIVE	YES 2 1	40			city Cuban, Mexic 2 DNO Spec		en, etc.)			White, etc.
	B	3 Widowed 4 Divorced				1	, , , ,	X	.,,.			Speci	White
		15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
	5 H	Elementary/Secondary (0-12)	College (1-4 or 5	- Man	Do NOT us	vork done dur se ratirad.)	ing mos	of working					
	릴	12 1949-1971 U.S. ARMY RETIRED MILITARY											
nce	COMPLET	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)											
		FRANCIS P. BRADY EVA HELINSKI											
ed	H												
to to	임	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mrs. Rita Brady  265 Scotts Manor Dr. Glen Burnie, MD 21061											
90		Mrs. Rita Brady									.e, M	D 210	061
ts		20a_METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of JU. 22, 1995) 20c. LOCATION — City or Town, State											
Ē		4 ☐ Donation 6 □ Other (Specify) CROWNSVILLE MD VET. CEM. CROWNSVILLE, MARYLAND											
9	- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Kirkley-Ruddick Funeral Home											
хад													
18	Daugh 421 Crain Hwy. S.E. Glen 1												MD 21061
9	П	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one cause of each line.											
E	- II	IMMEDIATE CAUSE (Final											Onset and Death
š		resulting in death) - a. Cardopuluonary arrest											
Jen 1	N	DUE TO (OR AS A CONSEQUENCE OF):										1, 0	
5	<u> </u>	Sequentially list conditions. The Hyocardial Infarefrom meday										R&S Than	
mat	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury).										she day	
Tan.	¥ I	cause. Enter UNDERLYING	Attorio	o. Oneste	. 1/	en. W	Ao	1000					′
Jer .	윤ᆙ	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):											
8		resulting in death) LAST		(**************************************	, T. T. T. T. T. T. T. T. T. T. T. T. T.	,.							j l
			d		-								
-	- 111	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuae given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
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20	<u> </u>	1 YES 2 IF NO OF DEATHS											
윤	Σ∥	tepper telle earl											
23	Ä	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEA	TH YE	SONO		UNCERTA	N 🗆				
item 23	<del>े</del> ∥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	H (Check only	y one)						
	SICI	1 TES 2 NO		ER/Outpatient 3	□ DOA	OTHER:	g Home	5 Residence	6 Other (S	Specify)			
	PHY	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TIM		lc. INJU		28d. DESCE	NBE HOW IF	NJURY OC	CURED	
	8	1 Natural 5 Pending	(month, b	vay. rour)	INJ		WOR	K? S 2 NO					
		2 Accident 28s PLACE OF IN.HIRV — At home form street feeton; office										nute Number	
00	ш	8 Could not be determined  8 Could not be determined  8 Could not be determined  8 Could not be determined											
item	<u> </u>												
=	COMPLET	(Check only 1 CERTIFYING PHYSIC											
Ë	ō I	2 MEDICAL EXAMINE	R: On the beals of a	xamination and/or I	rrvestigatio	n, in my opin	lon, de	ith occured at th	e time, deta an	d place, and	d due to th	ne cause(a)	and manner as stated.
-	U I	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(a) and manner as stated.  29b. SIGNATURE AND TITLE-OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)											
2	m	Barry Belen	70-	- Mrs				03603	711		D. DAT		20, 1995
=	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	SE OF DEATH STEE	4 27) /Em-	Orlint)		2 2000	<u>ر</u>				
		BARRY BERCOVITZ,	1.6 D										
				028 Rich	ie H	wy. G.	len	Burnie	, MD 2	1061	Sui	te 1	10-112
		IN 2 2 1995 Juli d	12. REGISTRA	R'S SIGNATURE									



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BALLIMORE, MARYLAND 21215-0020	n certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phys	nding physician and completely filled in by the funeral director, page 5 should be detached for use as the buris
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FOR STATE BEGISTRAR

		REG. NO.
		1. DECEDENT'S NAME (First, Middin, Last) PHILLIP L. BROWN 2. DATE OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)   F UNDER 1 YEAR   F UNDER 24 HRS.   7. DATE OF BIRTH (Month, Day, Year)   Outline   DAYS   HOURS   MINN.   (Month, Day, Year)
should		90. FACILITY NAME (If not Institution, give street end number)  90. CITY, TOWN OR LOCATION OF DEATH  90. CITY, TOWN OR LOCATION OF DEATH
1, 2, 3	СТОВ	North west Hospital Center Randallstown Balto
t. Pages	DIRE	106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. INSIDE CITY LIMITS? 1 $\square$ YES 2 KNO
isit permit.	UNERAL	10e. STREET AND NUMBER  10f. ZIP CODE  10g. CITIZEN OF WHAT COUNTRY?
020 physician. burial-transit	FUNE	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Merried  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— 14. RACE — American Indian, Black, While, atc. Black, While, atc.
nding as the	ED BY	3 Wildowed 4 Divorced  IF YES, GIVE WIR OR DATES  1 YES 2 NO Specify:  Specify: Black  16. DECEDENT'S EDUCATION  18a, DECEDENT'S USUAL OCCUPATION  16b, KIND OF BUSINESS/INDUSTRY
2 8 2	L	16. DECEDENT'S EDUCATION (Specify only highest grade completed)  18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working  Ife. Dg NOT use retired.)  16b. KIND OF BUSINESS/INDUSTRY
the hospital detached for	COMPL	11th grade NA Labrer Steel
MARYLAND retained by the hospit 5 should be detached notified at once.	BE CO	17. FATMER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Melden Surname)  Edith E. Green
MARYL retained by 5 should be	2	19b. MAILING ADDRESS/(Street end Number or Rural Route Number, City or Town, State, Zip Code)
Page page		20e, METHOD OF DISPOSITION  20e, METHOD OF DISPOSITION  20e, ACE AND ACCOUNT OF TOWN, State  20e, ACE AND ACCOUNT OF TOWN, State  20e, ACE AND ACCOUNT OF TOWN, State
O o to		Donation 5 Other (Specify) Garnson Forgit Ver 198395 (Oungs Mills, Md
- 0		22. NAME AND ADDRESS OF FACILITY,  MOUTH F. H. WOST  (12.6) A 12.0 Po 14.0 Po
BAnours after of or removal.		23. PART I. Enter the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heert failure. List only one cause on each line.  Approximate interval Reference.
F 90 F		MANAGEMATE CALLOS (Fig.)
s760 ted within 23 completely fill ial, cremation,: event, the		DUE TO (OR AS A CONSEQUENCE OF):
OX 6876C te be executed wi sician and compli prior to burial, or traumatic ever	NO	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):
BOX sate be hysician prior t	RTIFICATION	Cause. Enter UNDERLYING CAUSE (Pleases or Injury CAUSE (Pleases or Injury)
eath certifical attending phy mal Hygiene 1	RTIF	thet initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DIABETES MELLITUS TYPE IV
DS, In deat the attental Mental	IL CE	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS
O Had beed b	EDICAL	PERFORMED?    PERFORMED   AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
REC requires been sign of Healt	Σ	1 YES 2 NO
23 eg 8	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)
VITAL CIAN: The law prificate has be the State Dept or item 23	YSIC	EXAMINER?  1 YES 2 NO  1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)
O # ## 5 3	r PHY	27. MANNER OF DEATH  28b. DATE OF INJURY (Month, Disy, Year)  28b. TIME OF INJURY AT WORK?  M t   Yes 2   NO
0 5 4 9 7	D BY	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, ferm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, building ste (Specific Route Number)
DIVISION OR ATTEN DIRECTOR: hours after Item 28 It	ET	An opposition of the state of t
	COMPLETED	(Check only one)  CERTIFIER  (Check one)  CERTIFIER  (Check only one)  CERTIFIER  (Check only one)  CERTIFIER  (Check only one)  CERTIFIER  (Check only one)  CERTIFIER  (Check one)  CERTIFIER  (Check one)  CERTIFIER  (Check one)  CERTIFIER  (Check one)  CERTIFIER  (Check one)
TO THE HOSPITAL TO THE FUNERAL De filed within 72	BE C	29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
TO THE Do filed	70	30. NAME AND ADDRESS OF PERSON WHO COMPLETE CAUSE SI DEATH (ITEM 27) (Nypo, Print)
		RAYNOLD DEPESTRE NORTHWEST HAS PITH CENTER
		31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  July 2 2 1995
		DHMH-16 Rev 1/8
	. 1	
1	07	

9c. COUNTY OF CEATH

N/A

10g, CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify:

3. TIME OF DEATH

A

2:50

10d. INSIDE CITY

Black

Approximate

Interval Between

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TES 2 NO

29d. DATE SIGNED (Month, Day, Year)

Onset and Death

14. RACE — American Indian, Black, White, atc.

1 X YES 2 NO

B. BIRTHPLACE (State or Foreign Country)

Mississippi

2. DATE OF DEATH MONTH

June

STATE REGISTRAR

OLIVIA

1. DECEDENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS (Month, Day, Year) AUG. 3, 1923 DAYS HOURS 1 M 2 K F 215-40-8375 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 1406 E. Coldspring Lane Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD N/A Baltimore permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 1406 E. Coldspring Lane 21239 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 YNO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EOUCATION 18a. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gra during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Housewife vrs 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Shelly Hicks to BE Mary Kinney notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Henry Buck Coldspring Lane/Balgimore, MD 21239 406 E 9 20a. METHOD OF DISPOSITION
1 X Burial 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must DRUID or other "R"TDGE ☐ Donation 8 ☐ Other (Specify) \_ CEMETERY 6-27 PIKESVILLE.MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY March Funeral East hours after death. 1101 E. North Avenue/Baltimore, MD 21202 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. 6 IMMEDIATE CAUSE (Final the disease or condition\_ cremation. Neradratu event. reaulting in death) certificate be executed within burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL has been signed by the Dept. of Health and I amy t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \overline{\overl Dept. DR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate I hours after death with the State HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★Residence 8 ☐ Other (Specify) 10 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT marked, TIME OF 28d, OESCRIBE HOW INJURY OCCURED with 1 Netural 5 Pending Investigation М 1 YES 2 NO death В 2 Accident 28a. PLACE OF INJURY — At home, farm, street, lactory, offica building, etc. (Specify) 49 3 Sulcide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be after 28 i 4 Homicide determined item 29a. CERTIFIER

(Chack only

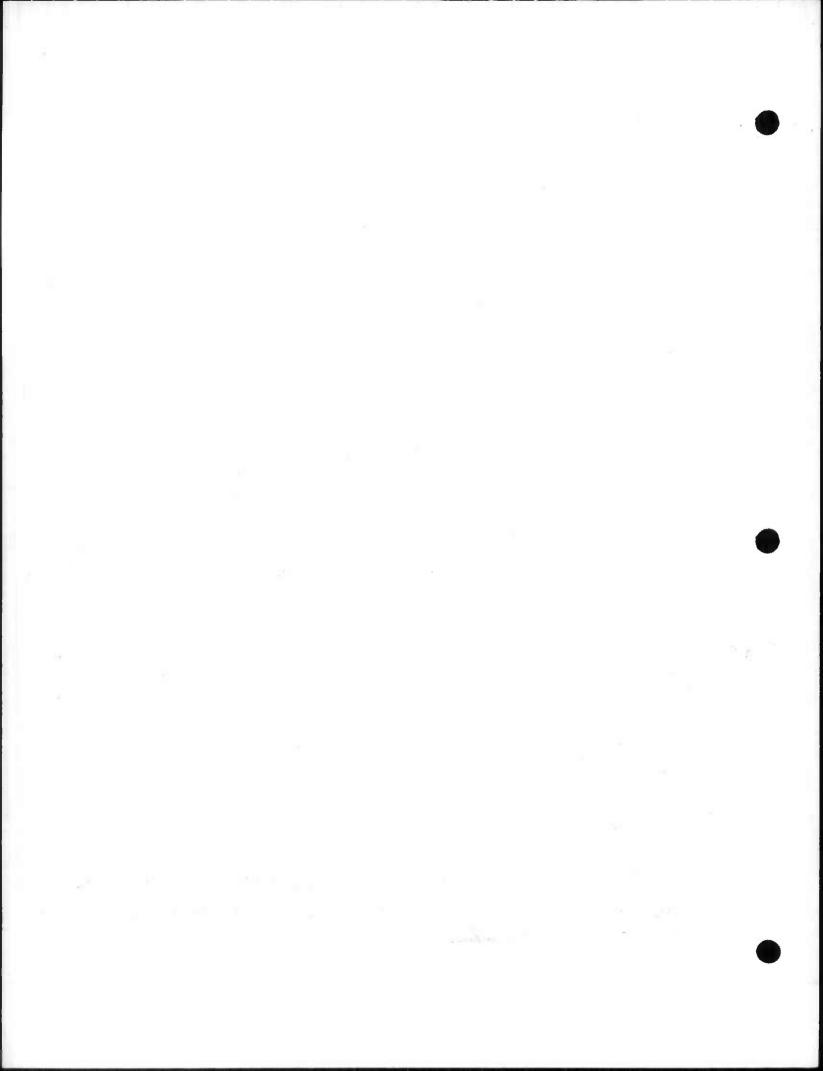
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL CO DE FIED WITHIN 72 M IMPORTANT: If it HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER BE D37238 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. WOKE St. BALTO 2020 130, John Hopkin Hospital 600

CAROLYN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

**CERTIFICATE OF DEATH** 

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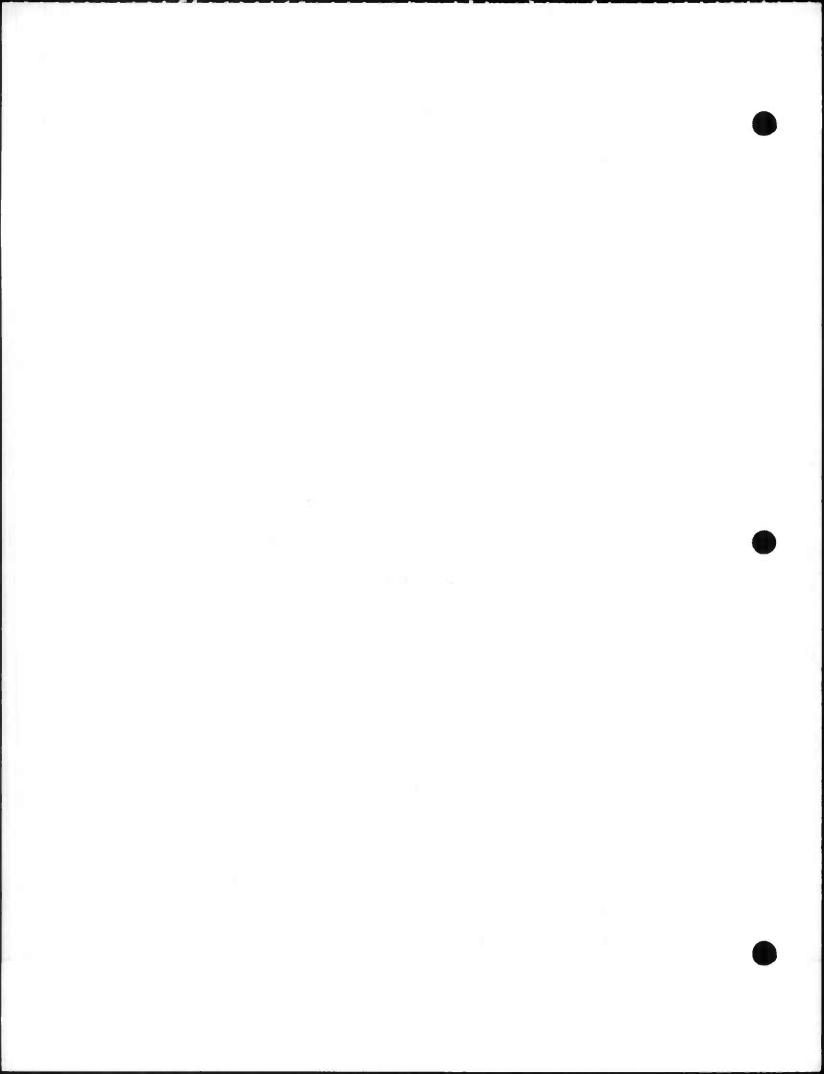


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DIVISION OF VITAL RECORDS, P.O. B

ter death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE OF M			ENT OF H		MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)	7	RR	10/11	/ ×/	2. DATE OF DEATH MONTH	DAY	3. TIME OF OFATH			
	4. SOCIAL SECURITY NUMBER 5. SEX	70 Y	8. BIRTHPLACE (State or Foreign								
	216 16 2968 1		S.C.								
DIRECTOR	BON SECOUR HOSPITAL		BALTO. CITTY								
REC	10a. STATE 10b. COUNTY		10d. INSIDE CITY								
	MD. BALTO. CITY		BAL	TIMORE	ZIP CODE		100 CITIZ	#☐ YES 2 ☐ NO ZEN OF WHAT COUNTRY?			
FUNERAL	619 n. PAYSON ST.				21217			JSA			
BY FUN		TEVER IN U.S. ARMI		13. WAS DECE	NOENT OF HISPA	NIC ORIGIN? (Specify an, Puerto Rican, etc.) by:	Yea or No				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4 or 5-2)	(Give	EDENT'S USUA kind of work of to NOT use retir	AL OCCUPATION fone during mos red.)	N t of working	BUSINESS/INDI					
MPL	12 0		MEMARE	R		НОМ	IE .				
	17. FATHER'S NAME (First, Middle, Last) ONIE GRIER					LIE G	RIER				
) BE	19a. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADD	RESS (Street an		Route Number, City or 1		Code)			
2	VERONICA GIBSON		-			. BALTO.		21223			
	20a, METHOO OF DISPOSITION  1	20b. PLACE AN COMMETTER, Crome BALTIM	story or other pl	lece)	127/95		cation — city or town, State timore, MD?				
	21. SIGNATURE OF EURIPAL SERVICE LICENSEE	1		22. NAME AN	ADDRESS OF FA						
-	23. PART N Enter the diseases, or complications the	Caused the deal	h Do not e	1300 E	UTAW PL	BALTO.	MD. 21	est, Approximata			
	ahock, or heert fellure. Liet only one ceu IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	(Of AS A CONSEOU	red	lind	Th	far	tus	Interval Batween Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST  b. // CAUSE (Disease or injury that initiated events reaulting in death) LAST										
PHYSICIAN: MEDICAL	PART II. Other eignificant conditions contributing to	deeth but not ree	oulting in the	e underlying	cause givan in	PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
. M	DID TOBACCO USE CONTRIBUTE TO CA	USE OF DEAT	H YES [		UNCERTAI	NΠ		1 TYES 2 NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH (C/								
HYSI	1 ☐ YES 2 (NO 1 ☐ Inputient 2 ☐ 27. MANNER OF DEATH 28e. DATE OF	ER/Outpatient 3 I				6 Other (Specify) 28d. DESCRIBE HOT	V IN HIRY OCC	TIBED			
ВУ РІ	1 Naturel 5 Pending (Month, D	ıy, Year) -	INJURY	WOR	IK? ES 2 NO	200. DEGOTABE 110	THOUSE CO.	ONED :			
	2   Accident Investigation   3   Suicide   8   Could not be determined   4   Homicide   Homicide   Could not be determined   28e. PLACE OF INJURY — At home, term, atreet, tectory, office   building, atc. (Specify)   28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
COMPLETED	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of a medical Examiner: On the basis of a medical examiner.										
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	mz	- m		29c. LICENSE NUI	MBER 3 55	29d. DATE	SIGNED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE  ROSITA R. C.I	CILZ	27) (Type, Print)	Bo	ON SE	Cour	s F	tospiTAL			
	31. DATE FILED (Month, Day, Year) JUN 2 2 1995	R'S SIGNATURE	A								



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PERSON

2 2 1995

Gil

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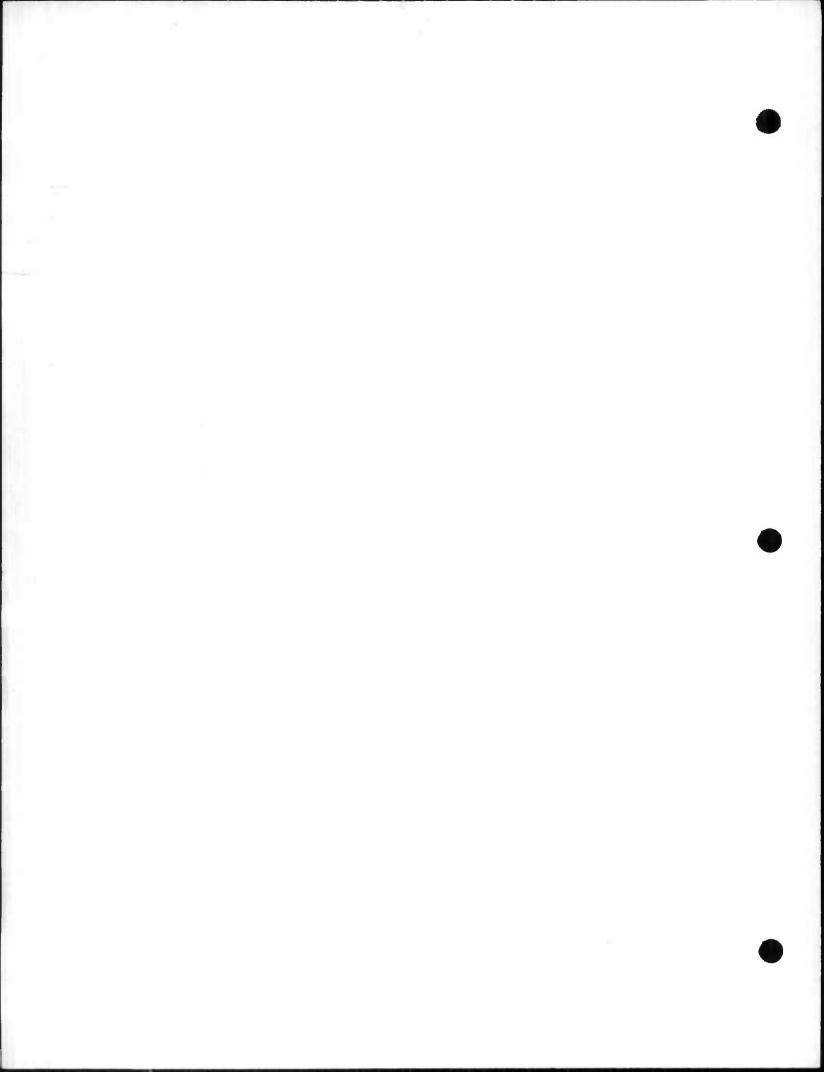
	Item1 7-5-95 Film	mG725 W.H.	Per F/I	1						Ct	18811			
	FOR STATE REGISTRAR	STATE OF MA					IEALTH AND DEATH	MENTAL HYGIEI						
	1. DECEDENT'S NAME .	BROTH	POTHERS Leolia Brothers 2. Date of Death MONTH DAY 9 SAR 3. T											
	4. SOCIAL SECURITY NUMBER 240565294	5. SEX 1 M 2 F	8. AGE (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) +/22/	4	Q S. BIRTINPLACE (State or Foreign Country) NORTH CAROLINA				
OR	90. FACILITY NAME (If not institution, give:		rigad	AL			R LOCATION OF D	EATN	9c. COI	UNTY OF D	EATH N/A			
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	γ		10c. CIT	Y, TOWN O	R LOCAT	ION		10d. INSIDE CITY					
		TIMORE		1	PARK	/ILL	E		1 YES 2 XNO					
FUNERAL	100. STREET AND NUMBER	T 4170 477777				101	ZIP CODE				YHAT COUNTRY?			
NE	7933 WEST MORE	LAND AVENT					21234			U.S.A				
В	1 Never Married 2 Married 3 M Widowed 4 Divorced	FORCES? 1 [ IF YES, GIVE WA	YES 2 X	IO		If yes, specify Cuban, Maxican, Puerto Rican, etc.)  1 YES 2 NO Specify:  Specify:					BLACK			
回	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G/	ve kind of v	USUAL OC	CUPATIO	ON st of working	16b. KIND OF BU	JSINESS/IN	DUSTRY				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	Do NOT US HOME!	e retired.) MAKEF	2		0.						
SON	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER'S NA	AME (First, Middle, Maide	n Surname)					
BE	ENOTH BARN	ARD						INDIA WILLIAMS						
2	19a. INFORMANT'S NAME (Type/Print)  JEAN B. COLEMAN							Route Number, City or To			102/			
	20s. METHOD OF DISPOSITION													
	1 M Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  NEW OAK GROVE CEMETERY 06-25  ELIZABETH CITY													
	21. SIGNATURE OF FUNERAL SERVICE LI	Hailes	STERLING ASHTON						AL HO	ME, I	INC.			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.										Approximate			
	IMMEDIATE CAUSE (Fine) disease or condition			01.43		. 14				Onset and Death				
	resulting in death)	DUE TO (C	DUE TO (OR AS A CONSEQUENCE OF):								30 Min			
z	CORONAMY AMERY DILEGIE										UNKN.			
일	Sequentially list conditions, if any, leading to immediate	DUE TO (O	DUE TO (OR AS A CONSEQUENCE OF):											
음	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (O	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	that initiated events resulting in death) LAST  d. CHONIC RENACTATIONS  d. CHONIC RENACTATIONS										11			
- 1	PART II. Other significant condition	a contributing to de	eeth but not re	eaulting I	n the un	derlying	ceuse given in	Part I. 24a, WAS AI	AUTOPSY	24b.	WERE AUTOPSY FINDINGS			
집	IPJU 4x	DEPE	N DEN	2 0	ING	ET	€ζ	PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?			
PHYSICIAN: MEDICAL											1 TES 2 NO			
AN	DID TOBACCO USE CONT	RIBUTE TO CAU					UNCERTAI	N 🛛						
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 Inpetiant 2 XER/Outpetiant 3 DOA  4 Nursing Home 5 Realdence 6 Other (Specify)													
훒	27. MANNER OF DEATN	JURY	28b. TIME	E OF	28c. INJI WO	JRY AT	28d. DESCRIBE NOW	INJURY OC	CURED					
BY	1 Netural 5 Pending 2 Accident Investigation		(Month, Day, Year) INJURY M				ES 2 NO							
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF I building, sto	e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29a. CERTIFIER (Check only one)	CIAN: To the best of m	y knowledge, des	th occurre	d at the tir	ne, deta	and place, and due	to the cause(e) end me	nner as sta	ted.				
00	2 MEDICAL EXAMINE		ninstion and/or in	rvestigation	n, In my op	olnion, de		e time, data and place, and due to the ceuse(s) and menner as stated.						
O BE	296. SIGNATURE AND TITLE OF CERTIFIE	Ofen	-M	)		29c. LICENSE NUMBER 29-				d. DATE SIGNED (Month, Day, Year)				

D CAUSE OF DEATN (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

ratigion matinamas ades

DHMH-16 Rev 1/89

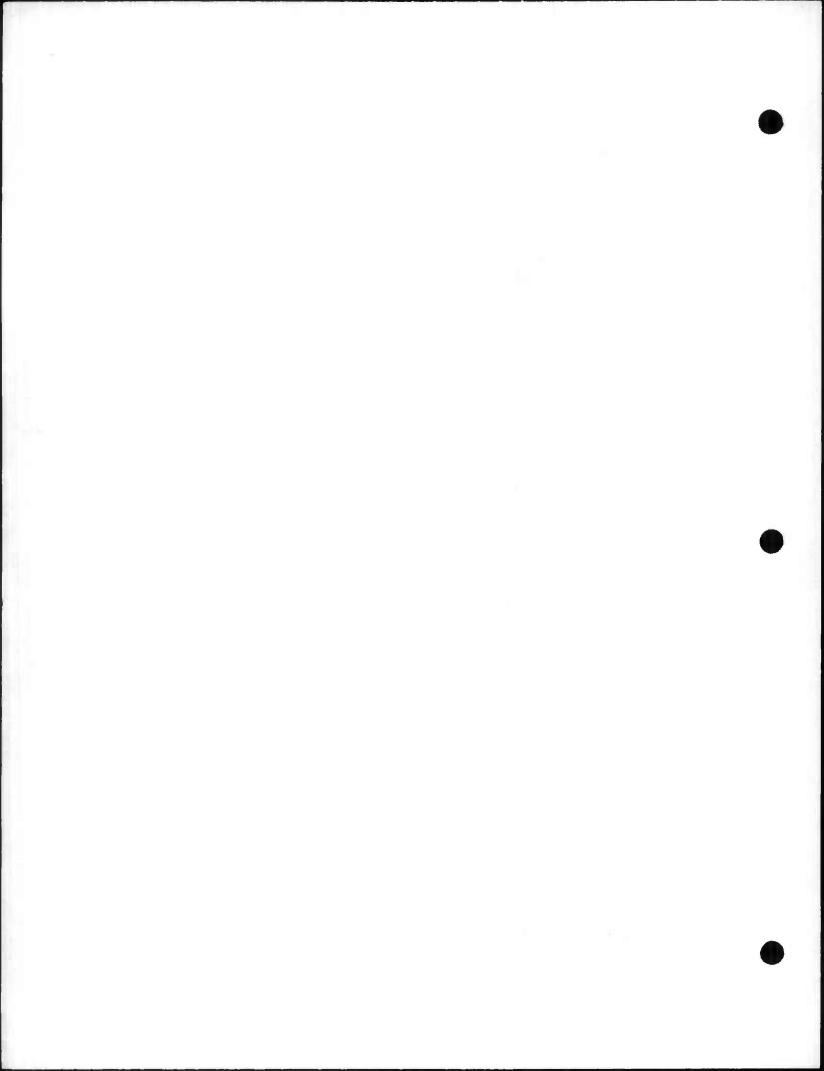


hysician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hyghene prior to burial, or remotion, or remotal.
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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)	BECK	er			2. DATE OF DEATH MONTH DA	W 19	EAR 3, TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	7/	BIRTHPLACE (State or Foreign				
	210-03-01/1		94 yrs.	MONTHS DAYS	HOURS MIN.	DEC 16, 19	900	MARYLAND				
00	90. FACILITY NAME (If not institution, give etre			9b. CITY, TOWN O	R LOCATION OF DE			Y OF DEATN				
DIRECTOR	CARROLL COUNTY GI	CAR	ROLL									
EG	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY				
		RROLL	7	WESTMINS	STER			1 TYES 2 NO				
FUNERAL	104. STREET AND NUMBER	NOT F		101.	ZIP CODE			N OF WHAT COUNTRY?				
INE	200 ST. LUKE CIE	CLE 12. WAS DECEDENT EVER IN	III C ADMED	1	21158		<u> </u>	.S.A.				
	1 X Never Merried 2 Merried	FORCES? 1 YES	2 X NO	If yes, spe	ecify Cuben, Mexice  2 X NO Specify	HC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	or No- 14	. RACE — American Indian, Black, White, etc.				
) BY	3 Widowed 4 Divorced			1 1 163	Z IX NO Speciny	r.		Specify: WHITE				
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	(TION ompleted)	16a. DECEDENT'S U (Give kind of wo	ork done during mos	IN sI of working	16b, KIND OF BUS	INESS/INDUS	TRY				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	SECRI	ETARY		OFFI	CE WO	RK				
COMPLET	17. FATNER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Meiden						
BE C	EMIL BECKER	ξ			BARBA							
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street er		Route Number, City or Town		ode)				
-	JOANN SHEELY					ELLICOTT CI						
	20e. METNOD OF DISPOSITION  1 Suriel 2 Cremation 3 Removal from State  4 Donellon 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of cemeter, crematory or other piece)  CHESAPEAKE CREMATORY 06-20-95  BELTSVILLE, MARYLAND											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	► VP.00.	Alan		BRADL	EY-ASHTO	N FUNERAL	L HOME, INC.					
	23. PART I. Enter the diseases, or co	mplications that caused	the death. Do no	2134	WILLOW S	PRING RD.,	BALT	MD. 21222				
	ahock, or haart failure. Li IMMEDIATE CAUSE (Final	st only one causa on as	ich ilna,		-o or aying, cool	rac cardioc or reapi	atory arrest	Approximata interval Between Onset and Death				
	disease or condition resulting in death)  a. MYOCANDIAL INFANCTION  [ week											
	DUE TO (OR AS A CONSEQUENCE OF):  CONVESTIVE HE ART FAILURS I WERE											
NO	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):											
CAT	cause. Enter UNDERLYING CAUSE (Disease pr injury  C. Se(S)S											
E	CAUSE (Disease of Injury that initiated events resulting in death) LAST											
CERTIFICATION	d.											
AL	PART II. Other algnificant conditions	contributing to death bu	it not resulting in	the underlying	cause given in		AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS				
MEDIC						1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ME						_ /		1 - YES 2 NO				
PHYSICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAIN	10						
SICI	EXAMINER?	HOSPITAL:		OTHER:	-0.500000							
H	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TIME	OF 28c, INJU		28d. DESCRIBE HOW IN	JURY OCCUR	ED				
BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI		ES 2 NO							
- 6	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— Al home, term, str	eet, factory, office		261. LOCATION (Street e. City or Town, Stete)	nd Number or I	Rural Route Number,				
E .												
COMPLETED	29e. CERTIFIER (Check only one)  CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee atated.  CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee atated.											
	296. SIGNATURE AND TITLE OF CERTIFIER	1 1 1	4.()		29 EVLICENSE NUM							
TO BE	"Van 11, 5 cl	DJU,	DATE SIGNED (Month, Day, Year)									
F	30. NAME AND ADDRESS OF PERSON WHO	GEORL, M	TN (ITEM 27) (Type, P		101/AC	AVENUS	2 /	LE MINER				
	31. DATE FILED MONTH, Day, Year 1995	REGISTRAR'S SIGNA	Reveal				1 14	ANYCAND				



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0	그 원	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner m
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	TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with an hours after death. Page	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a flowurs after death. Page 170 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JERRY** COOPER JR. JUNE 95 5:20 P 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 6. AGE (in vrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTNPLACE (State or Foreign Country) 212-90-5860 1 M 2 F DAYS HOURS MIN. AUG.4,1973 BALTIMORE, MD 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6500 BLK.BUSHTY STREET BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1 XES 2 NO FUNERAL 10e. STREET AND NUMBER 10s. CITIZEN OF WHAT COUNTRY? 1302 ELLWOOD **AVENUE** 21213 UNITED STATES 11, MARITAL STATUS
1 (2) Never Married 2 (3) Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 YNO Specify: 14. RACE --- American Indian, Black, White, atc. BY Specify: BLACK 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) 븡 vrs. STUDENT COLLEGE 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First Middle Maiden Surname **JERRY** COOPER SR. CAROLYN CHAPMAN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 CAROLYN COOPER 1302 ELLWOOD AVENUE, BALTIMORE, MD 21213 2 20a METNOD OF DISPOSITION
XX Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must CEDAR OF HILE CEMETERY 6-24 ANNE ARUNDELCO. MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH A VE. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition Multiple Gan event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WUNCERTAIN I PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 X YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Xother (Specify) ON SIDEWALK marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 6-19-95 1718 M Subject 1 YES 2 NO В 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 69 COMPLETED 6 Could not be 4 Homicide 28 determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 = 2X MEDICAL EXAMINER: On the basic of examinetion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER B 29d. DATE SIGNED (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201



2

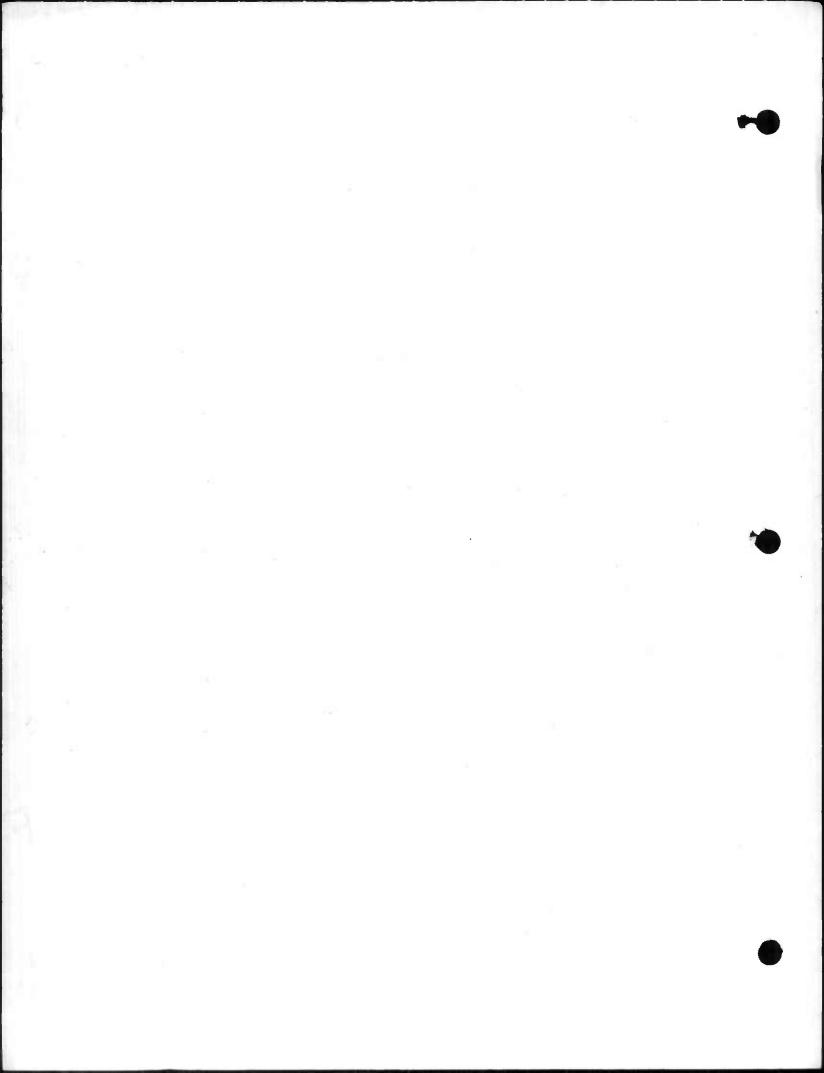
avid

31. DATE FILED (Month, Day, Year)
JUN 2 2 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Parler

2. RESISTRAP SIGNATURE

JUNE 20,1995



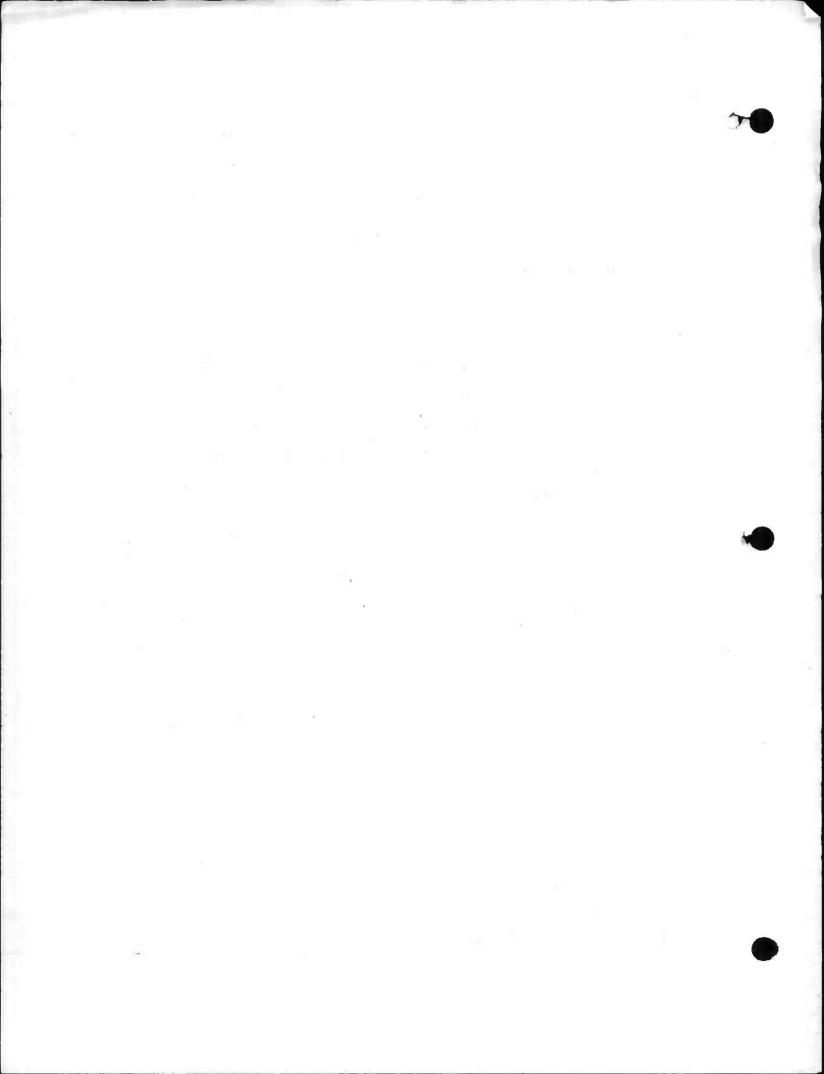
1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last									2. DATE O	F DEATH DA	ly .	YEAR 3	. TIME OF DEATH
A. S.		Anna Cukierman June 13,1995										925A M			
		4. SOCIAL SECURITY NUMBER	5. SEX		in yrs. last 7 7	birthday) YRS.	IF UNDER	1 YEAR	IF UNDER	24 HRS. MIN.		Day, Year)		Country)	ACE (State or Foreign
pinous	1	380-62-0727  9a. FACILITY NAME (If not institution, give	/ /	ina.	96. CITY, TOWN OR LOCATION OF DEATH					March 19,1918/ Ukraine					
en en	E I	Hebrew Home Of		r Ma	ch		_								
1, 2,	ECTOR	RESIDENCE OF DECEDENT		1 110	1511.				kvil	те			IMOII	tgom	
Pages	DIRE	10a. STATE 10b. COUN					Y, TOWN C								0d. INSIDE CITY LIMITS?
permit. Pages		Maryland Mor	tgomery			R	ocky		Le or, ZIP CODI	E .	10g. CITIZEN OF				T COUNTRY?
75	FUNERAL	6121 Montrose	Rd.						208	52	Ukrain				
020 physician. burial-transit	5	11. MARITAL STATUS	12. WAS DECEDED	IT EVER IN	U.S. ARM	/ED			CENDENT C	F HISPAN	NIC ORIGIN?			14. BACE -	- American Indian, White, atc.
215-0020 attending physician.	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced  FORCES? 1 YES IF YES, GIVE WAR OR DATI				2 NMO It yes, specify Cuban, Maxic 1 ☐ YES 2 NO Speci						cart, etc.,		Specify:	
	ETED	15. DECEDENT'S ED (Specify only highest grad			(Gh	e kind of	USUAL O	CCUPATI	ION lost of working	ng	16b. )	CIND OF BUS	SINESS/INC	DUSTRY	
0 P P	PLE	Elementary/Secondery (0-12)	College (1-4 or 5	+)			se retired.)				77.5	wh C	aha	0.1	
AND 2.  the hospital of detached for once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	3		Te	ach	er	-	18. MOTI	HER'S NA	ME (First, Mi	Lgh S		01	
8 8 E	ш	Israel Epelm	an						7		h Bro				
MARYLAND retained by the hospit 5 should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)			19b	MAILING	ADDRESS	(Street	777		Route Numbe			Code)	
		Valentine Cuki	erman	-						Dr	., Mo				
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION  1 Burlel 2 Cremation 3 Re 4 Donation 6 Other (Specify)	moval from State	cem	netery, cren	natory or o	of DISPOS ther place)			2	DATE			City or Town	
ALTIM death. Page funeral dire sxaminer n		21. SIGNATURE OF FUNEIAL BETWICE LICENSEE 22. N/								On.	CILITY P-T	4 Fa.	LIS	Cnur	cn, va
0 - 0		· Enil Ill	melse	*	2						on Fi				
ely hed in by nation, or remo		23. PART I. Enter the diseases, or abook, or heart feiture IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. List only one ce	use on e	sch line.							ec or respi	ratory ar	rest,	Approximats Interval Between Onset and Death 512 Hpg
68 ecut buria atte	NO	Sequentially list conditions,	b. Deme	CORASA	CONSEC	C .	ep	US	800	w					
P.O. BOX h certificate be ending physician I Hygiene prior h or other traur	CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  CAVC byo uascular Accident  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Veutncular Swan + for NPH  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									>7yr2				
x ag ath		PART II. Other significent condition	ns contributing to	death b	ut not re	sultina	in the ur	derivir	na ceuse i	alven In	Part I	24s. WAS AN	ALITOPSY	24b W	VERE AUTOPSY FINDINGS
ECORDS quires that the d n signed by the f Health and Me ows any Injur	AEDICAL											PERFOR	MED?	0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
E 5 50 4		DID TOBACCO USE	CONTRIBUTE	TO	CAUS	E OF	DEAT	H Y	YES 🗀	NO				1	☐ YES 2 ☐ NO
AL Pass has Deg	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?							PLACE OF D	EATH (Ch	neck only one)				
F VIT.	YSIC	1 NES 2 NO	HOSPITAL:	☐ ER/Outp	atlent 3	□ DOA	OTHE		me 5 🗆 Ra	sidence	6 Other	(Specify)			
	ВУ РН	27. MANNER OF DEATH  1 Netural 5 Pending Investigation	28a. DATE OF			28b, TIM	IE OF JURY M	W	JURY AT ORK? YES 2	NO	28d. DEŞC	RIBE HOW I	NJURY OC	CURED	
0 5 4 5 1	9	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined  25a. PLACE OF INJURY — At home, tarm, street, tactory, of building, etc. (Specify)											ite Number,		
DIVISION ATTEN DIRECTOR: hours after item 28 i	PLET	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best o	f my know	ledge, des	th occurr	ed at the t	ime, dat	a and place	, end dua	to the caus	e(s) and man	ner sa ste	ted.	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: H	COMPL	one) 2 MEDICAL EXAMI													and manner as stated.
THE HOSPI THE FUNER Ried within	ш	296. SIGNATURE AND TITLE OF CERTIFI	ER							ENSE NUI			29d. DAT	E SIGNED (	Aonth, Day, Year)
5 5 3 X	TO B	May 8 hee	war.	MS	>			046410 > 6/13/95							
1		May T. 8N		M D	H (ITEM	eb k	w t	one	e, 61	05	Mon	tros	e Ro	A, R	ekville,
7		" JUN 2" 2 1995	32 REGISTR	AR'S SICH	ATURE										

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be not not attend the State Dent of Health and Mental Hydiene polor to burial command on removal
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hours after death with the State Dent of Health and Mental Hydiene notor to huize commation or removal

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the ho	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 . STATE	STATE OF N							MENTAI	L HYGIEN	E			
	REGISTRAR		C	ERTIF	ICAT	E OF	DEA	ГН		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE MONTE	OF OEATH	AY	YEAR	3. TIME OF GEATH	
	WALTER J.  4. SOCIAL SECURITY NUMBER	CHANEY 5. SEX			_		,		Jun		19	995	7:00 A M	
	217-09-1551	5. SEX 1 XM 2 F	6. AGE (In yrs. Id		IF UNDE MONTHS	DAYS	HOURS	24 HRS. MIN.	(Month	OF BIRTH I, Day, Year)		Country)		
			10-17-1920 Ma											
(c)	96. FACILITY NAME (If not institution, give street and number)  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH													
DIRECTOR	2727 Kirkleigh Rd. Dundalk Baltimor										ore			
l iii	10a, STATE 10b, COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	ION					1	IOd. INSIDE CITY	
1 %	Maryland Bal	timore			ח	unda	1 lz					100	LIMITS?	
7	10e. STREET AND NUMBER	CIMOTE					ZIP COD	E			10a, CIT		IAT COUNTRY?	
FUNERAL	2727 Kirklei	ah Rd.				177	212	22				SA	AI COUNTAIN	
Z	11. MARITAL STATUS	12. WAS OECEDENT FORCES? 1	EVER IN U.S. A	RMED	13	. WAS DEC			NIC ORIGIN	? (Specify Yes			- American Indian.	
	1 Never Married 2 📉 Married	FORCES? 1 IF YES, GIVE W	X YES 2  AR OR DATES	NO OM		If yes, spe	cify Cube	n, Mexico	in, Puerto F	licen, etc.)	0.10	Black,	lack, White, etc.	
BY	3 Widowed 4 Divorced		W, II				- M no	Specif	y			Specify:	White	
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. D	ECEDENT'S	USUAL (	CCUPATIO	ON of of working		16b.	KIND OF BUS	BINESS/INI	DUSTRY		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+	, .	Give kind of le. Do NOT u			at Ur WORD	v						
MP	8		St	ceelv	ork	er			A	rmco	Stee	21		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						- 1			fiddle, Maiden				
BE	Joseph Chaney									salek				
0	19a, INFORMANT'S NAME (Type/Print)		11							Number, City or Town, State, Zip Code)				
	Ruby T. Chane			2727	Ki	rkl	eigh	n Ro	l Ba	altim	ore,	Md	21222	
	20a. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Ram	oval from State		AND DATE			ma of		DATE	20c. LO	CATION -	City or Town	ı, Stata	
	4 Donation 6 Other (Specify)		Mead	dowr i	.dge	e Mei	m. F	ark	6-2	24 E	1kri	dge,	Md.	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		-	22	NAME AN	D ADDRE	SS OF FA	CILITY					
	Enthony (	alt (a	71.00	10									undalk	
	23. PART I. Enter the diseases, Dr	complications that	ceused the d	leathy bo r	ot ente	r the mod	da of dvi	DO SHO	h as card	Point	RQ ratory an	<u> </u>	Approximate	
	snock, or neart reliure.	List Dnly Dne ceu	se Dn eech lin	ie. ()			,		46 5415	ieo or roup.	ratory at	wat,	Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	11 0	DADAAA	enal carcumana								Onset and Death		
	resulting in death)		OR AS A CONSE			CHO.	,						3MC>	
7					,								İ	
ERTIFICATION	Sequentially list conditions, if eny, leading to immediate	DUE TO (	OR AS A CONSE	EOUENCE O	F):								+	
8	cause. Enter UNDERLYING													
Ē	CAUSE (Disease or Injury that initiated events	OUE TO (	OR AS A CONSE	EOUENCE O	F):									
1	resulting in death) LAST	d.												
ਹ														
MEDICAL	PART II. Other algnificent condition	s contributing to	deeth but not	reculting	In the u	nderlying	ceuse g	iven in	Part I.	24s. WAS AN PERFOR		Al	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
Di									_	1 [ YES 2	NO		OMPLETION OF CAUSE F DEATH?	
												1	TYES 2 NO	
Ä	DID TOBACCO USE CONTI	RIBUTE TO CAI					UNC	ERTAIN	ИП					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEAT	OTHE									
YSI	1 TYES 2 DOM	1 Inpetiant 2 I		3 DOA		rsing Home	6 EM	sidence	6 🗆 Other	(Specify)				
표	27. MANNER OF BEATH  1 Antural 5 Pending	26s. DATE OF (Month, De		26b. TIM INJ	E OF URY	26c. INJU WOI			28d. DES	CRIBE HOW II	NJURY OC	CURED		
B	2 Accident Investigation				М		ES 2	NO						
	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF building, o	INJURY — At he	oma, farm, i	treet, tac	tory, office	ì		261. LOCA City o	TION (Street a town, State)	nd Number	or Rural Rou	te Number,	
E														
COMPLETE	29a. CERTIFIER (Check only													
O													nd manner as stated.	
20h SIGNATINE AND TITLE OF CENTIFIED							29c. LICE	NSE NUN	18ER		29d, DAT	E SIGNED (M	lonth, Day, Year)_	
ш	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, Your)  00  10  10  10  10  10  10  10  10  1						The state of the s							
	Maures 1	( Veno	47					112	72	- 1	<b>&gt;</b> /	0/21	195	

21204

Francis Carmody M.D. 7505 Osler Drive Towson, Md.

31. DATE FILED (Month, Day, Year)

22. REGISTRAR'S SIGNATURE

DDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Steelworker

Armco S

Joseph Chaney

Rubf T. Chaney

Anna Marsalek

2727 Kirkleigh Rd Baltimo

Meadowridge Mem. Park 6-24 El

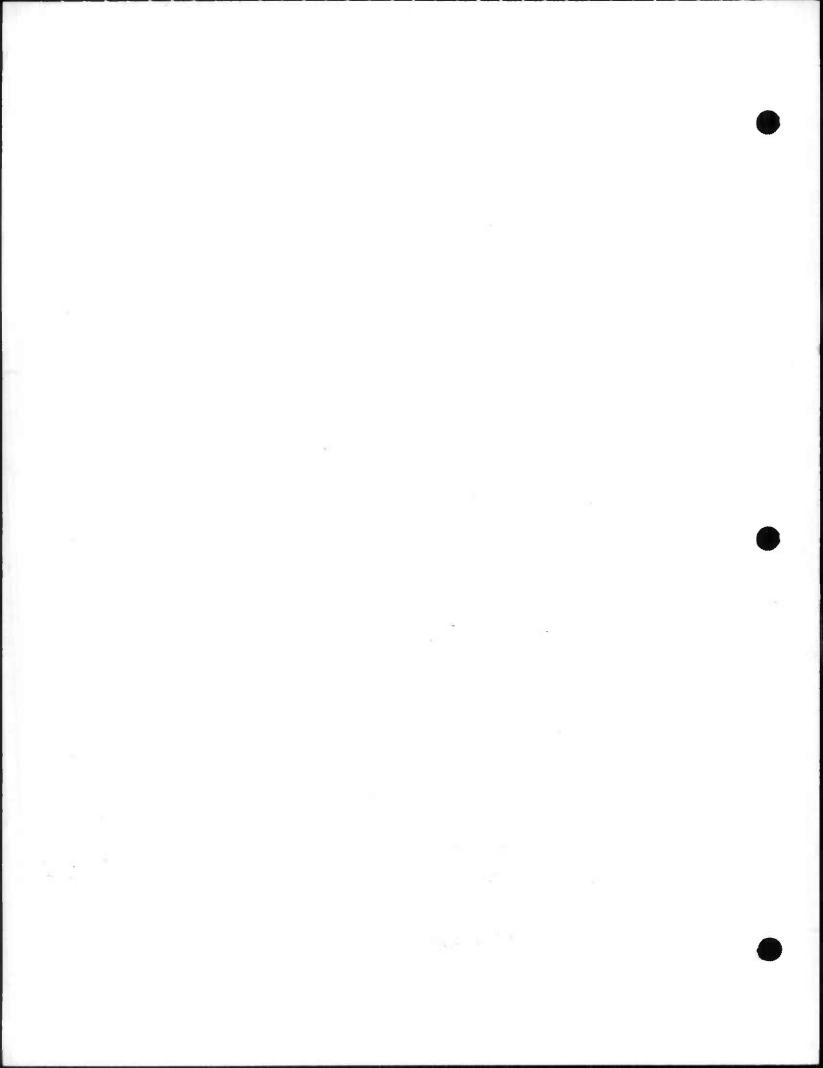
arthory Colt Connelly

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiens prior to burlat, cremation, or removal.	ed, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
O THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal,	PORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, it	
TO THE HC	TO THE FU	IMPORTA	

	1 - STATE OF MAR		ENT OF HEALTH AND I	MENTAL HYGIEN	_				
	1. DECEOENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH			
	Alice CI	HAILLOU		June 19, I	995 YEAR	7:10 P M			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. A	CIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday)     F UNDER 1 YEAR     F UNDER 24 HRS.   7. DATE OF BIRTH							
	216-24-9503 10M2XDF								
	9a. FACILITY NAME (If not institution, give street and number)	9b.	CITY, TOWN OR LOCATION OF OR	9c. COUNTY OF					
OR	Franklin Square Hospi	tal	Rossvill	е	Baltimo	ore			
۵	RESIDENCE OF DECEDENT  10e, STATE 10b, COUNTY	Law James and			1				
DIRECTOR	Md. Baltimore	10c. CITY, 10	WN OR LOCATION  ESSEX			10d. INSIDE CITY LIMITS?			
	10a STREET AND NUMBER		101, ZIP CODE			1 TYES 2 1 NO			
RA	132 Wiltshire Road			21221		WHAT COUNTRY?			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EV	FR IN U.S. ARMED.	13. WAS DECENDENT OF HISPAN						
	1 Never Married 2 Married FORCES? 1 Never Married IF YES, GIVE WAR O	ES 2 NO	If yes, specify Cuban, Mexica	n, Puerto Ricen, etc.)	Ble	CE — American Indian, ick, White, etc.			
ВУ	3 Wildowed 4 Divorced	TO DATES	T TES 2X NO Specin	<i>y.</i>	Spi	White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUA	AL OCCUPATION lone during most of working	16b. KIND OF BUS	SINESS/INDUSTRY	WILLIAM			
H	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use reti	ed.)		_				
MP	12th	Housev	rife	OW	n home				
	17. FATHER'S NAME (First, Middle, Last)		1000000	ME (First, Middle, Malden					
BE	William Cullison  19e. INFORMANT'S NAME (Type/Print)		-	hie Dibb					
9			RESS (Street and Number or Rural I						
	Paul Chaillou		iltshire Ro						
	1 Duriel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)	20b. PLACE AND DATE OF DIS cemetery, cremetory or other pa	ece)	1	CATION — City or				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Oak LAwn (	emetery 6/2	2//95	Baltimo	ore Md.			
1	· RT.	1//	Connelly Fu	neral Hor	me of H	Essex			
-	1. lery conne	VII	300 Mago Arr	o Paltir	moro Me				
	23. PART I. Enter the diseases, or complications that cer shock, or heart fallure. List only one cause of	n each line.	nter the mode of dying, suci	h as cardiac or reapl	ratory arrest,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition Anterior	myocardial :	cardial infarction						
	resulting in death)	AS A CONSEQUENCE OF):							
-		artery disea	356			i 1			
2		AS A CONSEQUENCE OF):							
EA	cause. Enter UNDERLYING Diabetes								
E	that initiated events DUE TO (OR /	AS A CONSEQUENCE OF):							
CERTIFICATION	resulting in death) LAST Hyperlipidemia								
	PART II. Other algolificent conditions contributing to deel	h but not reaulting in the	underlying ceuse given in	Part I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS			
MEDICAL				PERFOR	MEO?	AMILABLE PRIOR TO COMPLETION OF CAUSE			
				1 🗆 YES 2	X NO	DF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES I	NO W UNCERTAIN			1 YES 2 NO			
IA	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH (C)		, 🖂					
SIC	EXAMINER?  1 YES 2 NO  HOSPITAL:  1 Inpatient 2 ER/		HER: Nursing Home 5 - Realdence	6 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH 28s. OATE OF INJU (Month, Day, Ye.	RY 28b, TIME OF	28c. INJURY AT	28d. DEŞCRIBE HOW IN	NJURY OCCURED				
BY I	1 Natural 5 Pending 2 Accident Investigation	injury	WORK? 1 YES 2 NO						
	3 Suicide 6 Could not be 28e. PLACE OF INJ building, atc. (	URY — At home, farm, street,	factory, office	281. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,			
	4 Homicide detarmined			Only of Town, State)					
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my ki	nowledge, dasth occurred at	he time, date and place, and due	to the causs(s) and men	ner as stated.				
S S	one) 2 MEDICAL EXAMINER: On the beals of examin	ation and/or investigation, in	my opinion, death occured at the	time, data and place, and	d due to the cause	(a) and menner as stated.			
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1	29c. LICENSE NUM	IBER	29d. DATE SIGNE	D (Month, Day, Year)			
	Toller Wintle	C.	D 41680		June	19,1995			
일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)							
		anklin Squar	e Dr. Baltimo	re, Maryla	nd 21237	7			
	31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S S  JUN 2 2 1995	IGNATURE							
	JUN 2 2 1995 Julia Blandson	Market .							



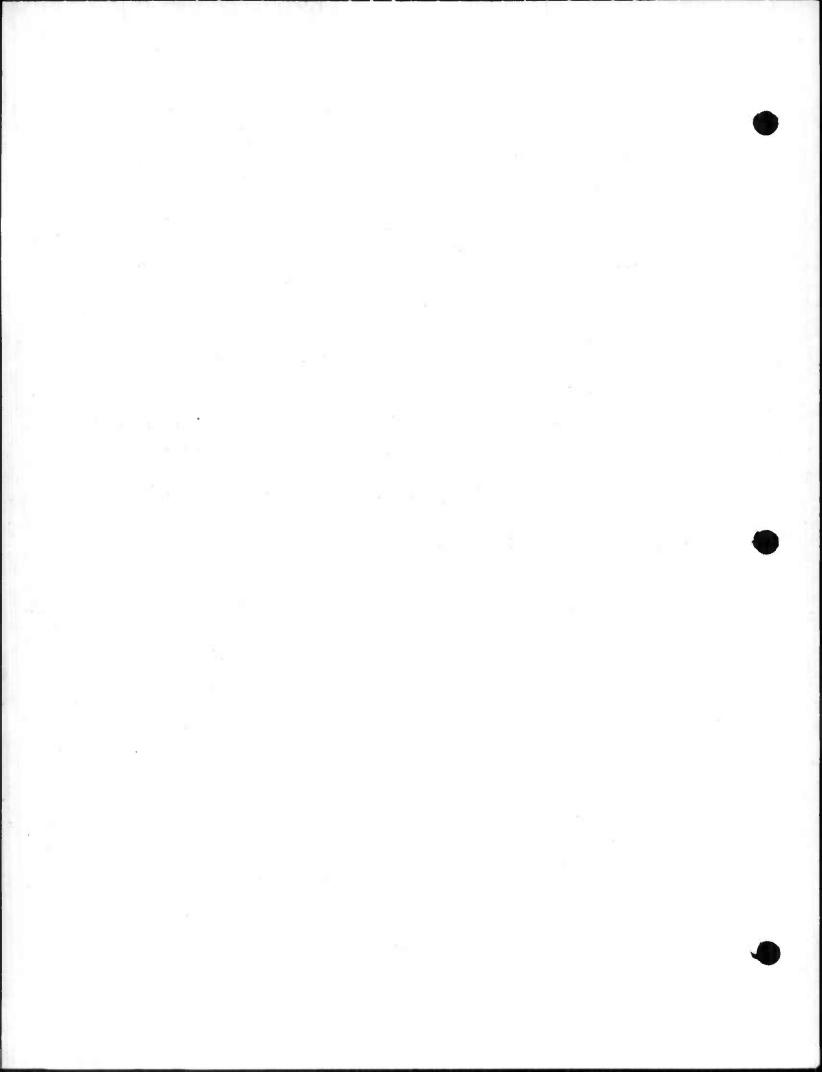
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HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	3 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR A	THE FUNERAL DIRECT filed within 72 hours	<b>4PORTANT: If Item</b>
Ε,	- 6	=

	REGISTRAR			CHILL	CALE	- DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)  Joanne Phyl	lis Cont	i				2. DATE OF DEATH MONTH D	W 102	(EAR 3. TIME OF DEATH	
							JUNE 1	5 199	1.00	
	4. SOCIAL SECURITY NUMBER 217-40-7455	5, SEX 6.	AGE (In yrs. les		IF UNDER 1 YEAR MONTHS DAYS	The state of the s	7. DATE OF BIRTH	10//	BIRTHPLACE (State or Foreign Country) Maryland	
Œ	9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital					or Location of DE		9c. COUNTY	Y OF DEATH	
유	RESIDENCE OF DECEDENT	Tal noop	Tear		Dai	n .				
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY,	Oc. CITY, TOWN OR LOCATION 10d. IN					
ā	Md. Ba:	ltimore		Mid	dleri	ver		LIMITS?		
A	10e. STREET AND NUMBER					Of. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
FUNERAL	42 Salix Co	ourt				21220		U.	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AR	MED			VIC ORIGIN? (Specify Yes	or No- 14	I. RACE — American Indian, Black, White, atc.	
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1   IF YES, GIVE WAR	OR DATES	10		S 2X NO Specifi			Society: hite	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)			SUAL OCCUPATOR done during it		16b. KIND OF BUS	INESS/INDUS	TRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	retired.)					
M P	9th			Beau	ıticia	n	Bear	uty S	hop	
	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maiden	Surname)		
BE	Carl M. Braun						M. Beck			
2	19a. INFORMANT'S NAME (Type/Print)						Route Number, City or Tow			
	Joseph Kelly								Md.21122	
	20a. METHOD OF DISPOSITION 1	oval from Stata	cemetery, cre	and date of Imetory or oth Apeak	FDISPOSITION ( Der place) Ce Cre	matory	DATE 20c. LO	Belts	ville, Md.	
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE			22 MARKE	AND ADDRESS OF FA	OII ITH		ome, 21222.	
	Edin 4. Le	Jens #	D0008	33					alto.,Md.	
	23. PART I. Enter the diseases, pr	complications that c	sused the de	eth. Do no	ot enter the n	ode of dying, auc	h as cardlec or respi	ratory srres	t, Approximate	
	shock, or haert fallure. Liet only one cause on each lina.  interval Between Onset and Dasth									
	disease or condition a. PULMONARY EDEMA  DUE TO (OR AS A CONSEQUENCE OF):								4 HRS	
Z	Sequentially list conditions, If any leading to immediate  b. PERICARDIAL EFFUSION  Due to (or as a consequence of):  1 Soft of the properties of the proper									
CERTIFICATION		DUE TO (OF	AS A CONSEC	QUENCE OF)	1 10	6.01			3 +4	
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente DUE TO (OR AS A CONSEQUENCE OF):									
Ē	that initieted evente DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
S		d								
A	PART II. Other significent condition	na contributing to de	eth but not r	eeuiting In	the underly	ng ceuse given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
EDICAL							t 🗆 YES 2		COMPLETION OF CAUSE OF DEATH?	
W								9	t   YES 2   NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUS	SE OF DEA	TH YES	NO I	☐ UNCERTAIN	10			
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC		(Check only on	)				
PHYSICIAN:	1 🗆 YES 2 NO	19 Inpatient 2 - Er	3/Outpatient 3	□ DOA	OTHER: 4 - Nursing Ho	me 5 🗆 Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH  1 Netural 5 Pending Investigation	26s. DATE OF IN. (Month, Day.		28b, TIME INJU	RY V	JURY AT ORK? YES 2 NO	26d. DESCRIBE HOW I	YJURY OCCUP	RED	
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF III building, atc.	IJURY — At ho . (Specify)	me, term, st	reet, tectory, of	Ica	26f. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,	
COMPLETED	29a. CERTIFIER				100000000000000000000000000000000000000					
절	(Check only 1 CERTIFYING PHYSI									
8	2 MEDICAL EXAMINE	R: On the beels of exem	ination and/or i	Investigation	, in my opinion,	death occured at the	time, data and place, an	d due to the c	cause(a) and manner sa ateted.	
BE (	29b. SIGNATURE AND TITLE OF CERTIFIE	9				29c. LICENSE NUM	IBER .		IGNED (Month, Day, Year)	
5	an m	mo				I AT24	38946	- Ju.	NE 15, 1995	
	30. NAME AND ADDRESS OF PERSON WHAT	O COMPLETED CAUSE			Print)	PIAL +	tosp. B.	ALT	MO	
	31. DATE FILED MONTH & 2 2 1995	SPECISTAR'S		64				1		
	The same read and the								1	

BALTIMORE, MARYLAND 21215-0020	The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the led within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

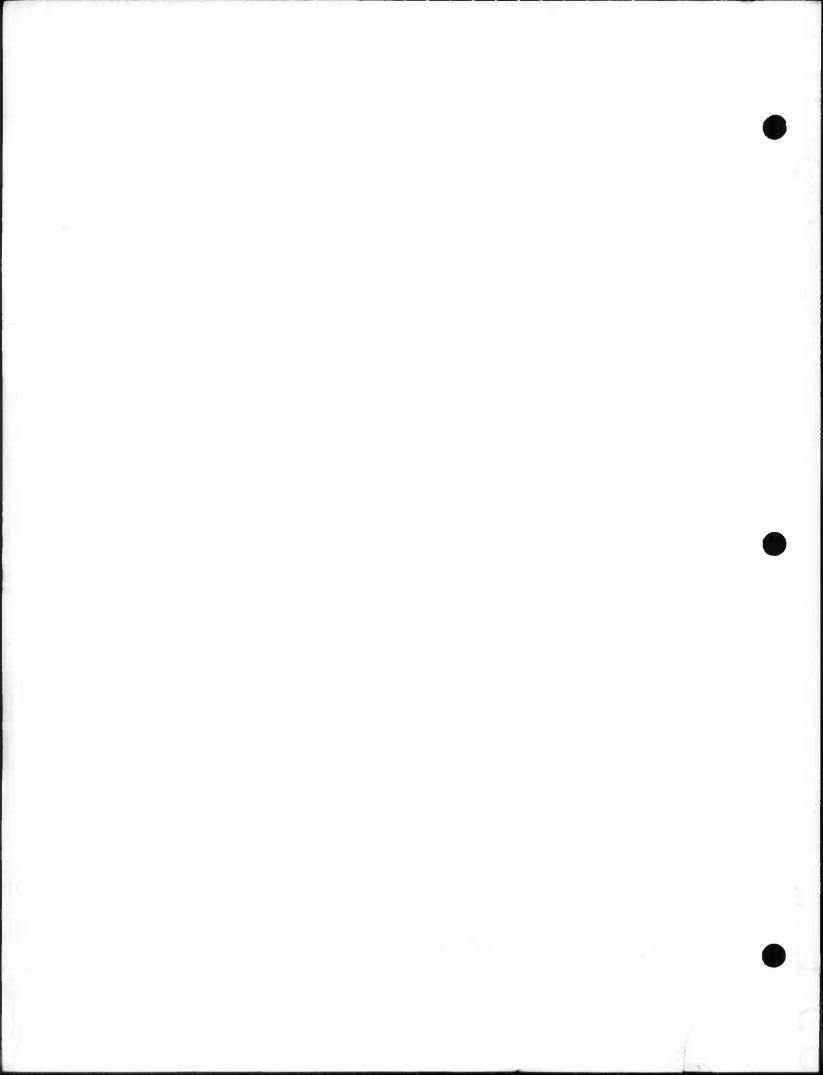
	FOR 1 STATE	STATE OF MARY		RTMENT OF HEALTH AND	MENTAL HYGIEN	E			
	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)		CERTII	FICATE OF DEATH	REG. NO				
	ALBERT		DURAN	יי	2. DATE OF DEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. lest birthday)			,1995	10:00a M BIRTHPLACE (State or Foreign		
	247-48-0452	1 🗷 M 2 🗆 F	63 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year)	0	Country)		
	Se. FACILITY NAME (If not institution, give s	treet and number)	0.5	9b. CITY, TOWN OR LOCATION OF	3/19/32 DEATN	9c. COUNTY	outhCarolina OF DEATH		
E C	TANGIER SOUND								
5	RESIDENCE OF DECEDENT			N/A		1 301	MERSET		
DIRECTOR				TY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?		
	Maryland Bal	timore	I	Pikesville			1 WES 2 NO		
FUNERAL		04		10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
l z	1 Belle Forte	12. WAS DECEDENT EYE	D IN II S ADMED	21208 13. WAS DECENDENT OF HISP	ALLIC OBIOLOGO AS		SA		
	1 Never Married 2 X Married				can, Puarto Rican, etc.)		RACE — American Indian, Black, White, atc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	Korec	1 TYES 2 KNO Spec	cny:	1	SpecifyBlack		
1 2	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	B USUAL OCCUPATION work done during most of working	16b. KIND OF BU	SINESS/INDUSTI	RY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	ise retired.)					
OMPLETED	10 th.	N /A	Owner		Truck				
-	17. FATHER'S NAME (First, Middle, Last)				NAME (First, Middle, Maiden				
	Ellie Durant  190. INFORMANT'S NAME (Type/Print)		Top MAILIA	EV1	ene McPhe				
TO B	Bishop Naomi Du	urant					•		
2	20a. METNOD OF DISPOSITION			le Forte Ct.F		CATION — City			
T T T T T T T T T T T T T T T T T T T	1 D Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from State	cemetery, crematory or						
	21. SIGNATURE OF FUNERAL BERVICE LIC	ZENSEE C		22. NAME AND ADDRESS OF I	6/23 Owi	ngs M	IIIS,MO.		
examiner	22. NAME AND ADDRESS OF FACILITY Carlton C. Douglass 1701 McCullohSt. Balto., Md.21217								
	23. PART I. Enter the diseases, or o	complications that cause	see Ohe death. Do						
	shock, or heart failure.	I let only one cause or	7		toti es ceruier di tespi	ratory arrest,	Approximate		
		Link Only One Cause Of	neath line.				Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	0					Interval Between Onset and Death		
	IMMEDIATE CAUSE (Final	. Drown		11					
event, inc	IMMEDIATE CAUSE (Final disease or condition reaulting in death)	. Drown	ning	11					
event, inc	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, laading to immediate	DUE TO (OR A	ning	DF):					
event, inc	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions,	DUE TO (OR A:	S A CONSEQUENCE C	)F): )F):					
event, inc	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A:	S A CONSEQUENCE	)F): )F):					
OF OTHER TRAINING OVER, THE ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A:	S A CONSEQUENCE C	)F): )F):					
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A)  DUE TO (OR A)  DUE TO (OR A)	S A CONSEQUENCE C	)년): )년):	n Part I. 24a, WAS AN		Onset and Death  Onset and Death  24b. WERE AUTOPSY FINDINGS		
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition reaulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR A)  DUE TO (OR A)  DUE TO (OR A)	S A CONSEQUENCE C	)년): )년):		MED?	Onset and Death  24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
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DIVISION OF VITAL RECORDS,

		1 - FOR STATE REGISTRAR	STATE OF MARYLA			HEALTH AND	MENTAL	HYGIEN	E			
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pin		4. SOCIAL SECURITY NUMBER  579-24-8833  9a. FACILITY NAME (If not institution, give sit	1□M2□NE 67	yrs. lest birthday) YRS.	IF UNDER 1 YEAR	HOURS MIN.	Jul	OF BIRTH , Day, Year) 23 , ]	927 W	ash:	ington, D	)(
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permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	Arundel		Y, TOWN OR LO	CATION			10d, INSIDE CITY LIMITS?			
ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physician. It is the following properties of should be detached for use as the burial-transit examiner must be notified at once.	ERAL	100. STREET AND NUMBER 4587 Muddy Cre	ek Road			101. ZIP CODE 20776			10g. CITIZEI		T COUNTRY?	_
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	TO BE	19a. INFORMANT'S NAME (Type/Print)  JoAnne Fitzger	ald			ot and Number or Aural	Route Numb	er, City or Town	n, State, Zip Go		0776	-
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Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 in by the funeral director, page 5 should be detached for use as the removal.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 ho	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the m
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH MONTH YEAR BETTY DOVE A 12:00a 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTYN
OCT. 14,1930 IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign 64 DAYS HOURS 218-26-1101 1 M 2 F Washington, DO YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1921 Ridgeville Road Edgewater DIRECTOR Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Edgewater 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1921 Ridgeville Road 21037 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 90 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married B 3 Widowed 4 Divorced 1 YES 2 NO Specify Specify: White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 10 Homemaker Household 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Archibald Coulter Myrtle Lowe 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Brandon J. Dove 118 River Road, Edgewater, MD 20a. METHOD OF DISPOSITION
1 1 Burlal 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Genetery Cremetory or other place)
Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/21 Annapolis, MD 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dal Hardesty Funeral Home, P.A. Annapolis 12 Ridgely Ave 21401 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat. Approximate interval Between shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finsi **Onsst and Death** disease or condition\_ 01 resulting in death) CERTIFICATION Sequentially list conditions, A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER?

ng Home 5 Residence 8 - Other (Specify) 1 - Inpatient 2 - ER/Outpatient 3 - DOA

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY 28c. INJURY AT WORK?

1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28d. DESCRIBE NOW INJURY OCCURED

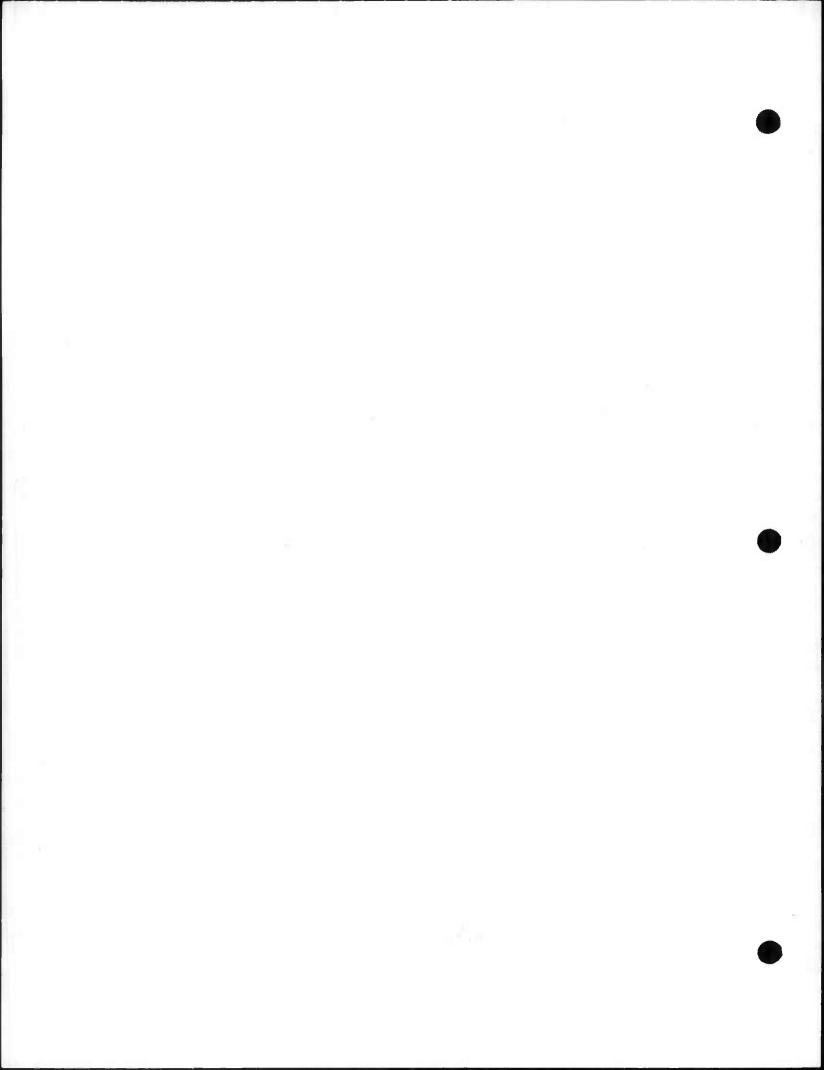
11 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the beals of examination and/or	investigation, in my opinion,	death occured at the time,	data and place,	and due to the caus	e(a) end manner as	a stated

Server Standard Hille Co		on call for	a Birbaum	AS		D29	5	71	P
30. NAME AND ADDRESS OF	PERSON WHO COMPLI	TED CAUSE OF DEAT	H (ITEM 27) (Type, Print)	/ /	1	1			m

1655 Crater blod suite 101 Crother MC Benez MD

8 Could not be



Approximata Interval Between Onset and Death

many years

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

12 2 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

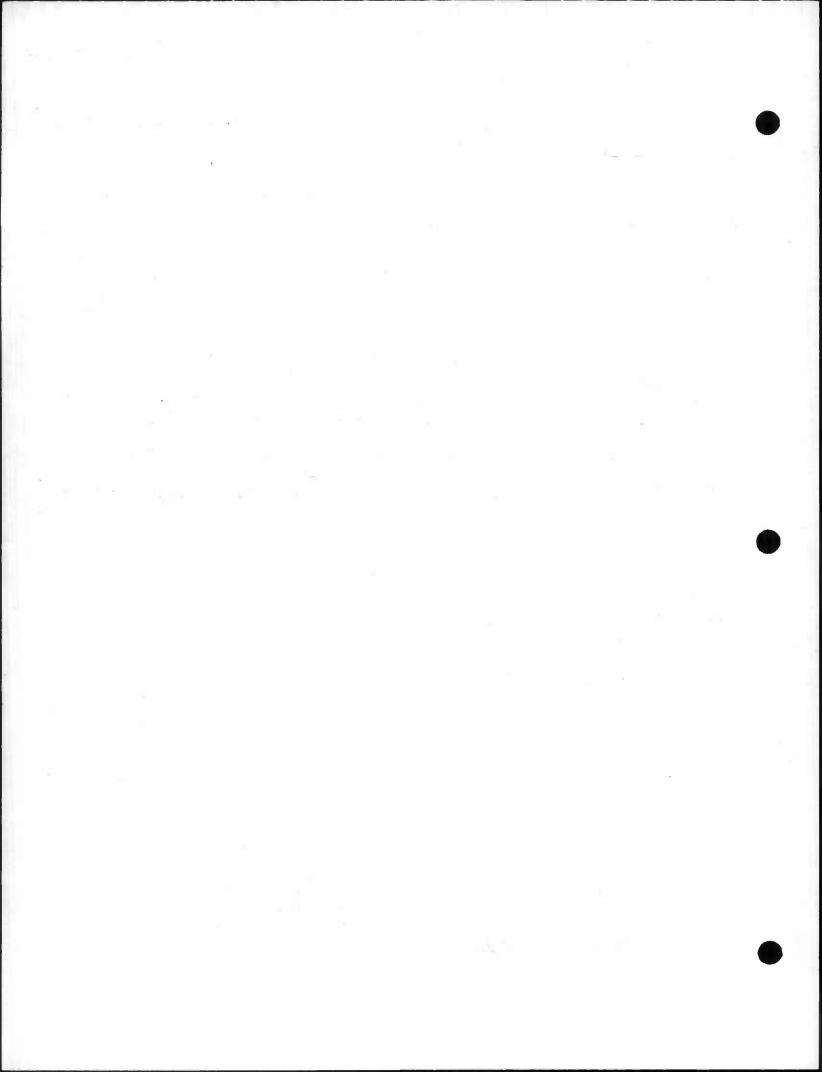
		MONTH DAY YEAR									3. TIME OF OEATH			
	ı	4. SOCIAL SECURITY NUMBER	Frank 5. sex	Ende 6. AGE (In yrs.		IF UNDER	WEAR	- mpr	R 24 HRS.	7. DATE O		1995		5:20A
P		218-03-1608	1 💢 M 2 🗆 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)	914	Countr	IPLACE (State or Foreign y) TYLAND
3 should	_	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN	R LOCATI	ION OF DE			9c. COUN		
6,	DIRECTOR	45 Wise Avenu RESIDENCE OF DECEDENT						Dund	lalk			1	Balt	imore
physician. burial-transit permit. Pages 1,		Maryland 10b. coun		imore	10c. CIT	Y, TOWN	OR LOCAT	TION	Dun	dalk	6			10d. INSIDE CITY LIMITS? 1 YES 2 NO
nsit perm	FUNERAL	100. STREET AND NUMBER  45 Wise Avenue	2				101	. ZIP COD	212	222				States
	BY FUN	11. MARITAL STATUS 1 Never Married 2 X Married 3 Vidowed 4 Divorced		NT EVER IN U.S.  YES 2 (MAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, atc.)  1  YES 2 X NO Specify:								
use	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)				"S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY						White		
he hospital o detached for once.	MP	8 Years			Pol	ice					w End		ment	
		17. FATHER'S NAME (First, Middle, Last)									ddle, Malden	Sumame)		
5 should be notified at	BE	Frank Enders 190. INFORMANT'S NAME (Type/Print)			105 MAN MAC	ADDRES	2 (0)		_	ine G	COCR r, City or Town			
	5	Mrs. Mildred Be	offo Fudor								Maryl		212	222
6 may be ctor, page nust be		20g, METHOD OF DISPOSITION		20b. PLAC	EANDDATE	OF DISPOS	SITION (Na	me of	Duric	DATE	-	CATION (		
a) 6) E		Genetic 2   Cremation 3   Removal from State   Commettery or other place), A Commettery   6/21/95   Baltimore, MD												
death. Page 6 may be e funeral director, page al. examiner must be		21. SIGNATURE OF SUMERAL SERVICE :	0/	eed		22.	Dude	a-Ruc	SS OF FAC	inera	l Home Dundal	206	Duna	lalk, Inc.
acuted within 24 hours after of and completely filled in by the i burlal, cremation, or removal.		23. PART I. Enter the diseases, or shock, or heart failers IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one ceu	it caused the use on each if	ne.								rat,	Approximata Interval Betwee Onset and Dea
th certificate be ex ending physician a I Hygiene prior to or other traum	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Joy DUE TO	(OR AS A CONS	SEQUENCE O	F):								
the d We line		PART II. Other significent condition	one contributing to	deeth but no	t resulting	In the un	derlying	cause	given in i	Pert I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO
een signed by of Health an	MEDICAL									-	T TES 2	ND		COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
5 8 0 5	ž	DID TOBACCO USE CON	TRIBUTE TO CA					UNC	ERTAIN	1-0				
ate har tate D	20	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ACE DF DEA	TH (Check	-	h /						
ICIAN Sertific the S	PHYSICIAN:	1 YES 2 NO	1 inputiant 2 26a. OATE OF			4 🗆 Nun	sing Hom	$\rightarrow$	sidence	6 Other (				
er this cath with	BY PI	Natural 5 Pending	(Month, D		28b. TIM	URY M		RK?	] NO	28d. DESC	RIBE HOW IN	JURY OCC	URED	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23:	ETED 1	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE D building,	of INJURY — At atc. (Specify)	home, farm,	street, fact	ory, office				ION (Street at Town, State)	nd Number	or Rural R	oute Number,
RAL DIRE	COMPLE		SICIAN: To the best of											
HOSP FUNE within		2 MEDICAL EXAMI		Automotive and/o	n mwengatio	m my o	prinon, de				no place, and			
TO THE TO THE De filed	TO BE	( pron	n mo		Janice	Ryde	n, M	D.		0609		29d. DATE	SIGNED	(Month, Day, Year)
	F 1	30. NAME AND ADDRESS OF PERSON W	THO COMPLETED CAUS	SE OF DEADS	THE POW	AMer	CAL	anta	*				-	-

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1005 N. Point Blvd. Ste. 700

32. REGISTRAR'S SIGNATURE CANTINOTO, MD 21224

DHMH-16 Rev 1/89



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BALTIMORE, MARYLAND 21215-0020	-
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SION OF VITAL RECORDS, P.O. BOX 687	ENDING DAVCICIAN. The last requires that the death cartificate he assessed
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OD ATTENDING DUVERIAN. The last requires that the death next fines he manufacted within the second death Dans & manufacted to the second death d

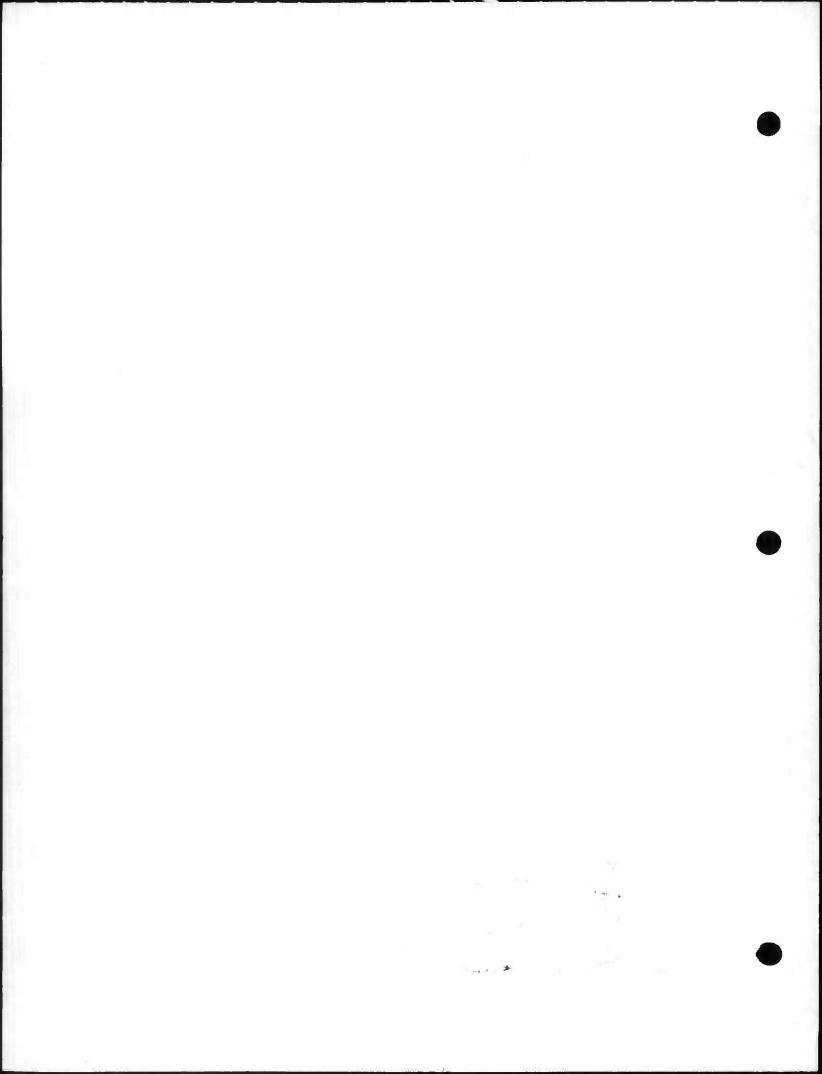
1 - STATE REGISTRAR

### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. DECEDENT'S NAME (First, Middle, Last) Charles Fleming										
		2. DATE OF DEATH MONTH DAY	yeab 0830 M							
4. SOCIAL SECURITY NUMBER 5. SEX J 6. AGE (In yrs. lest birthde	MONTHS DAYS MOURS MIN	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)							
226-14-1910 11XM2 = F 74 YRS		Feb 12, 1921	Va							
5 University HOSP Hall	96. CITY, TOWN OR LOCATION OF C	EATH 9c. C	OUNTY OF DEATH							
RESIDENCE OF DECEDENT	1 MITIMORE		NA							
10e. STATE 10b. COUNTY 10c.	CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?							
	Ja Hinore 101. ZIP CODE	10g.	1 YES 2 NO CITIZEN OF WHAT COUNTRY?							
10. STREET AND NUMBER  2 3 0 W. Fougette St  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 0 NO	2/22		11. SA							
	If yes, specify Cuben, Mexic		Black, White, etc.							
3 Widowed 4 ODivorced	1 TYES 2 NO Speci	ny:	Specify: Black							
(Specify only highest grade completed) (Give kind	T'S USUAL OCCUPATION of work done during most of working T use retired.)	16b. KIND OF BUSINESS.	INDUSTRY							
Elementary/Secondary (0-12) College (1-4 or 5+)	rpenter	Carpen	try							
12 Harale NA (a		AME (First, Middle, Malden Surnem	0)							
COPTIE Fleming	Hry	Britt								
Sulvan Fleming 725	NG ADDRESS Street and Number or Alval	Houte Number, City or Town, State,	Zip Code) M1/ 7/1/76							
20e_METHOD OF DISPOSITION 1 © Buriel 2 Cremetion 3 Removat from State Confidence, cremetory,	TE OF DISPOSITION /Name of	DATE 20c. LOCATION	- City or Town, State							
1 bd. Burlel 2 Cremetion 3 Removat from State 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE	nove rouional cer	1983/95 Baltin	nore, md							
22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY  23. SIGNATURE OF FUNERAL SERVICE LICENSEE  24. SIGNATURE OF FUNERAL SERVICE LICENSEE  25. SIGNATURE OF FUNERAL SERVICE LICENSEE										
23. PART i. Enter the diseases, or complications that coused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
shock, or heef feliure. List only one cause on each line.  iMMEDIATE CAUSE (Fine)  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest, and performed interval Between the mode of dying, such as cardiac or respiratory arrest, and cardiac or respiratory arrest, an										
disease or condition regulting in death) a.	>		10 mis							
DUE TO (OR AS A CONSEQUENCE			2 hrs							
Sequentially list conditions, if any, leading to immediate										
cause. Enter UNDERLYING CAUSE (Disease or injury	C.									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	OF):									
DART II Other significant conditions continues to death and an annual state of the										
PART II. Other algoriticent conditions contributing to death but not resulting	g in the underlying couse given in	PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE							
		1 TYES 2 NO	OF DEATH?  1 YES 2 NO							
		N 🗆								
- I TOURGE OF CONTRIBUTE TO CAUSE OF DEATH	EATH (Check only one)									
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:	OTHER:									
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 10 Impetient 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH 266. DATE OF INJURY 266.	OTHER: 4   Nursing Home 5   Residence	6 Other (Specify)  26d. DESCRIBE HOW INJURY	OCCURED							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH 26. DATE OF INJURY (Month, Dey, Year)  28. PLACE OF D  29. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  20. PLACE OF D  21. MANNER OF DEATH  22. PLACE OF D  23. PLACE OF D  24. PLACE OF D  25. WAS CASE REFERRED TO MEDICAL  26. PLACE OF D  27. MANNER OF DEATH  27. MANNER OF DEATH  28. PLACE OF D  28. PLAC	OTHER: 4   Nursing Home 5   Residence		OCCURED							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 Inpstlent 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH 26. DATE OF INJURY 26b. 1  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined determined 4 Homicide determined	OTHER: 4   Nursing Home 5   Residence  IME OF NJURY AT WORK? 1   YES 2   NO									
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  1 Inpatient 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH  28. PLACE OF D  10 Inpatient 2 ER/Outpetient 3 DOA  26. DATE OF INJURY  26. DATE OF INJURY  26. DATE OF INJURY  27. MANNER OF DEATH  28. PLACE OF INJURY  28. PLACE OF IN	OTHER: 4   Nursing Home 5   Residence  IME OF   28c. INJURY AT   WORK7   1   YES 2   NO    n, street, tactory, office	28d. DESCRIBE HOW INJURY of 28t. LOCATION (Street and Num. City or Town, Stete)	iber or Rural Route Number,							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	OTHER:  4   Nursing Home 5   Residence  IME OF   NJURY AT   WORK?  1   YES 2   NO   No   No   No   No   No   No   No	28d. DESCRIBE HOW INJURY 28t. LOCATION (Street and Num. City or Town, Stete) 28t. to the cause(s) and menner as	iber or Rural Route Number, stated.							
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  1 Inpstient 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH  28. PLACE OF D  1 Inpstient 2 ER/Outpetient 3 DOA  27. MANNER OF DEATH  28. PLACE OF D  28. PLACE OF D  29. CERTIFIER  (Check only  29. CERTIFIER  (Check only  29. MEDICAL EXAMINER: On the basis of exemination end/or investignt  29. SIGNATURE AND THE OF CERTIFIED	OTHER:  4   Nursing Home 5   Residence  IME OF   NJURY AT   WORK?  1   YES 2   NO   No   No   No   No   No   No   No	28d. DESCRIBE HOW INJURY 28t. LOCATION (Street and Num. City or Town, Stete) 28t. to the cause(s) and menner as time, date and place, and due to	iber or Rural Route Number,							
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   YES 2   NO  1   Inpstient 2   ER/Outpetient 3   DOA  27. MANNER OF DEATH  28. PLACE OF D  19. Inpstient 2   ER/Outpetient 3   DOA  27. MANNER OF DEATH  28. PLACE OF INJURY  (Month, Dey, Year)  (Month, Dey, Year)  (Month, Dey, Year)  (Month, Dey, Year)  29. CERTIFIER  (Check only One)  29. MEDICAL EXAMINER: On the basis of exemination end/or investigated and title of certifier  29b. SIGNATURE AND TITLE OF CERTIFIER	OTHER:  4   Nursing Home 5   Residence  IME OF   28c. INJURY AT   WORK?  1   YES 2   NO    n, street, tactory, office  arred at the time, date end place, end duction, in my opinion, death occured at the	28d. DESCRIBE HOW INJURY 28t. LOCATION (Street and Num. City or Town, Stete) 28t. to the cause(s) and menner as time, date and place, and due to	stated.							
25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO  26. PLACE OF D  HOSPITAL: 1 Pending Investigation  3 Suicide 6 Could not be determined  26. PLACE OF INJURY  26. DATE OF INJURY  26. PLACE OF INJURY  26. PLACE OF INJURY  26. PLACE OF INJURY  26. PLACE OF INJURY  27. MANNER DF DEATH  28. PLACE OF INJURY  29. CERTIFIER  (Check only one)  29. CERTIFIER  (Check only one)  2 MEDICAL EXAMINER: On the basis of exemination end/or investigation	OTHER:  4   Nursing Home 5   Residence  IME OF   28c. INJURY AT   WORK?  1   YES 2   NO   No   No   No   No   No   No   No	28d. DESCRIBE HOW INJURY 28t. LOCATION (Street and Num. City or Town, Stete) 28t. to the cause(s) and menner as time, date and place, and due to	stated.  attending the cause(s) and manner as stated.  but a signed (Month, Day, Year)  6 - 17-95							

DHMH-16 Rev 1/89

4+102



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

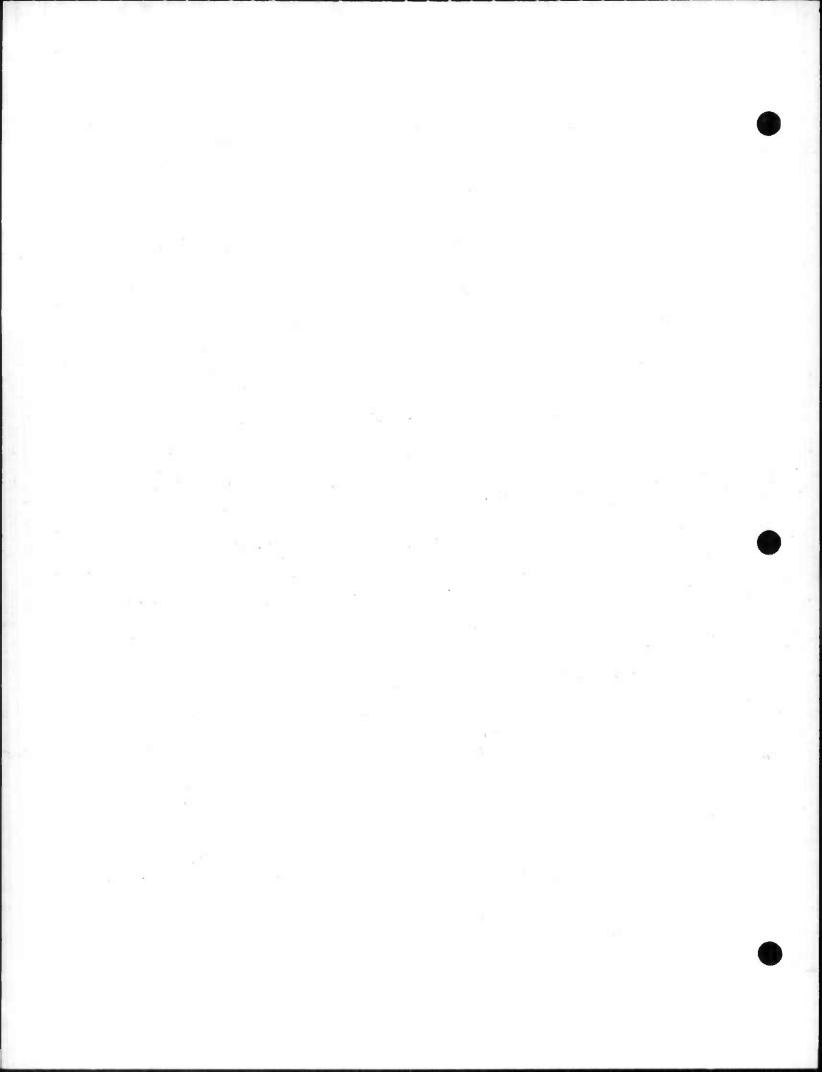
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

								1120.110			
	1. DECEDENT'S NAME (First, Middle, Last)	Can	- 14 -				2. DATE	OF DEATH	AY	YEAR	3. TIME OF DEATH
	IIIartha K	., tar	WEL				00	20	5 9	5	744 A
	A		(In yrs. last i		UNDER 1 YEAR	IF UNDER 24 HF	40.4	OF BIRTN		8. BIRTNI Country	PLACE (State or Foreign
	212-16-0117	□ M 2 💢 F	76	YRS.	HINS DAYS	HOURS MI	Apr		1919		nna.
- 6	9e. FACILITY NAME (If not institution, give street	and number)	1 1	98	CITY, TOWN	OR LOCATION O		• 10		NTY OF DE	
8	Hartora Memor	IN HOSE	Later		und	96.97	Gra	0.0	1/4	rte	422
K I	RESIDENCE OF DECEDENT	100	MINI		MANI	1000	Ola		141	70 10	31.40
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY, T	OWN OR LOC	ATION					10d. INSIDE CITY
ā	Maryland Han	rford			N/	Α					LIMITS?
7	10s. STREET AND NUMBER				T i	Of. ZIP CODE			10n CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	1330 614	enville Ro	ad				21078				
ž		WAS DECEDENT EVER		F0	I una no						States
	1 Never Married 2 Merried	FORCES? 1 YES	2 X NO		If yes, s	CENDENT OF NIS pecify Cuben, Me	xican, Puerto		or No—	14, RACE Black,	American Indien, White, atc.
BY	3   Wildowed 4 □ Divorced	IF YES, GIVE WAR OR I	DATES		1 🗌 YE	S 2 X NO St	ecify:			Specify	White
	15. DECEDENT'S EDUCATION	DM .	160 DECI	DENT'S HE	UAL OCCUPAT	.011					MILLICE
	(Specify only highest grade comp	pleted)	(G/ve	kind of work	done during n	iost of working	16	b. KIND OF BUS	SINESS/INC	DUSTRY	
ا ت	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)		specto	•		- 1	Airplan	o Dv	oduc.	tion
COMPLETED			111.	specia	JI					ouuc	1011
	17. FATHER'S NAME (First, Middle, Last)	and MacD	1-					Middle, Melden			
BE		pert Mac D					Orie_	Harper			
<u>و</u>	19e. INFORMANT'S NAME (Type/Print)					end Number or Ru					
- 1	Dr. Rita J. Lautz		1;	330 G	lenvil	le Rd.	Havre	eDe Gra	ace,	Md.	21078
	20e. METHOD OF DISPOSITION 1 [2] Burlal 2 Cremation 3 Removal	20	D. PLACE AN	DDATEOFD	SPOSITION (	iama of	OAT	E 20c. LO	CATION —	City or Tow	rn, State
	4 Donetion 5 Other (Specify)	Trom state Cer	Park	WOOD (	Cemete	rv 6/	23/95	Bai	ltimo	re	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSI					ND ADDRESS OF					
	▶ wilt	1	71911	, UI				Leonar			′
	Mulon	nnoel	大	~	5305	Harford	Rd.	Baltimo	ore,	Mary.	land 21214
	23. PART I. Enter the diseases, or companies, or heart fellure. List	only one cause	tha dast	h. Do not	anter tha m	ode of dying,	such aa car	diac or reapi	ratory an	reat,	Approximata
1	IMMEDIATE CALICE (CI)	4									Interval Batween Onset and Death
	disease or condition	acuta	Mu	1 / dia	Mark	In la	wite	กลี			1
i	resulting in death) a	OUE TO (OR AS	A CONSEQU	ENCE OF:	0000	4.17	0.000				4 minutes
- 1	-	Cornar Cornar	1	Sit		The					10 VALOR
፬	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	CONSEQU	ENCE OF):	sy.	Suu	21				10/8413
CERTIFICATION	cause. Entar UNDERLYING				0						
E	CAUSE (Disesse or Injury that initisted events	DUE TO (OR AS	A CONSEQU	ENCE OF):							1
Ē	resulting in death) LAST										1
빙	- d										+
ا ہے	PART II. Other significant conditions co	entributing to death i	out not res	ulting in t	ha undariyir	ng cause given	In Part I.	24s. WAS AN			WERE AUTOPSY FINDINGS
DICAL	Hypertens	in						PERFOR	. 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Congretane	Heart	Zan	leve	,			1 1 123 2	A NO		OF DEATH?
2	DID TOBACCO USE CONTRIBU	7				T LINICEDE	AINI CT				1 TYES 2 NO
¥ I	25. WAS CASE REFERRED TO MEDICAL	JIE TO CAUSE C			Check only one		AIN L				
PHYSICIAN:	EXAMINER?	SPITAL:		0	THER:	,					
Z I			patient 3			ne 5 🗆 Residen	ce 5 🗆 Othe	r (Specify)			
ᆵ	27. MANNER OF DEATH  1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)		28b. TIME OF	F 28c. IN	JURY AT DRK?	28d. OE	SCAIBE NOW II	NURY OCC	CUREO	
፳					M 1 🗆	YES 2 NO					
	2 Accident Investigation		f — Al home cify)	, ferm, atree	t, fectory, offi	Ce		ATION (Street e	nd Number	or Rural Ro	eute Number,
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spe	4 Homicide determined City or Town, Stete)								
	3 Suicide 8 Could not be	building, etc. (Spe									- 1
<u> </u>	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spe		occurred =	t the time de	e and place and	due to the co	use(e) and mo-	Der en etch	ad .	
<u> </u>	3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN:	: To the best of my know	rledge, deatl								and manner as stated
COMPLET	3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Or	: To the best of my know	rledge, deatl			death occured at	the time, date		d due to th	e cause(e)	
COMPLET	3 Suicide 8 Could not be determined  29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN:	: To the best of my know	rledge, deatl			death occured at	the time, date	end plece, en	d due to th	e cause(e)	end menner ee stated,  Month, Day, Year)
BE COMPLET	3 Suicide 4 Homicide  8 Could not be determined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Or	To the best of my known the beste of exemination	riedge, deati	estigation, ir	n my opinion,	death occured at	the time, date	end plece, en	d due to th	e cause(e)	
BE COMPLET	3   Suicide   8   Could not be determined    29a. CERTIFIER (Check only one)   2   MEDICAL EXAMINER: Or    29b. SIGNATURE AND TITLE OF CERTIFIER    30. NAME AND AOPRESS OF PERSON WHO CO	To the best of my known the best of exeminated	riedge, deati in end/or inv	estigation, in	n my opinion,	29c. LICENSE	NUMBER	end place, en	29d. DATI	e cause(e) E SIGNEO (	Month, Day, Year)
TO BE COMPLETED	3   Sulcide 8   Could not be determined    29a. CERTIFIER (Check only one) 2   MEDICAL EXAMINER: Or    29b. SIGNATURE AND TITLE OF CERTIFIER    30. NAME AND ADDRESS OF PERSON WHO CO	To the best of my known the beste of exemination	riedge, deati in end/or inv	estigation, in	n my opinion,	29c. LICENSE	NUMBER	end place, en	29d. DATI	e cause(e) E SIGNEO (	Month, Day, Year)
TO BE COMPLET	3   Sulcide 8   Could not be determined  29a. CERTIFIER (Check only 2   MEDICAL EXAMINER: Or 29b. SIGNATURE AND TITLE OF CERTIFY IN	To the best of my known the best of exeminated	riedge, death	estigation, in	n my opinion,	29c. LICENSE	NUMBER	end plece, en	29d. DATI	e cause(e) E SIGNEO (	Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

	REGISTRAR		CERTIF	CATE C	F DEATH	REG. NO	).				
	t. DECEDENT'S NAME (First, Middle, Last) ANNA	GLICKMA	N			June 18,	<b>~</b> 1995	YEAR	3. TIME OF DEATH 11:15 A. M		
	4. SOCIAL SECURITY NUMBER 577-44-5616	5. SEX 8. AC	96 vas.	MONTHS DAY		7. DATE OF BIRTH (Mapth, Dey, Year) JULY 4,	1898	Russ	LACE (State or Foreign		
OR	96. FACILITY NAME (If not institution, give 12502 Davan Driv	,			n on Location of D ver Spring		Mon	ty of DE			
2	RESIDENCE OF DECEDENT  10e. STATE 10e. COUNT										
FUNERAL DIRECTOR	Maryland Mon		lver S	Spring	<i>y</i> .			10d. INSIDE CITY THEYES 2 NO			
ERAI	100. STREET AND NUMBER 12502 Davan Drive			101. ZIP CODE 20904			U .	HAT COUNTRY?			
B⊀	11. MARITAL STATUS  1 Never Merried 2 Married  XX Widowed 4 Divorced	R IN U.S. ARMED ES 2XXNO DATES						- American Indian, White, atc.			
	15. DECEDENT'S EDU		18e. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	JSINESS/INDL	USTRY			
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 8th Grade	College (1-4 or 5+)		(Give kind of work done during most of working life. Do NOT use retired.)  Housewife Own Ho							
Ö	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maide	Sumeme)				
BE	Nathan Harris  190. INFORMANT'S NAME (Type/Print)					Braginsky					
5	Judith T. Cohen		Route	# 1, I	Box 738, M	Route Number, City or Too IcAlpin, F.	en, State, Zip Lorida	Code) 1 32	.062		
	20e. METNOD OF DISPOSITION  XX Burler 2 Cremetion 3 Removal from State  4 Donetion 5 Other (Specify)  20b. Place AND DATE OF DISPOSITION (Name of June 20 DATE Completely, cremetion, or other algorithm and the completely, cremetion, or other algorithm and the completely, cremetion, or other algorithm and the completely, cremetion, or other algorithm and the completely, cremetion, or other algorithm.  20b. Place AND DATE 20c. LOCATION — City or Town, State Campbelly, cremetion, or other algorithm.  20b. Place AND DATE 20c. LOCATION — City or Town, State Campbelly, cremetion, or other algorithm.										
	21. SIGNATURE OF FUNERAL SERVICE LI		enyer	STE		MEMORIAL :			OME, INC.		
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List only one cause on asch line.  Approximate interval Between Onset and Death of Cause (Final disease or condition resulting in death)  But to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST  DUE TO (or as a consequence of):										
MEDICAL CI	PERFORMED?  1 YES XXXPO  OF DEA								WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH	YES   NO	ΣП					
₹ I	25. WAS CASE REFERRED TO MEDICAL				PLACE OF DEATH (CA						
잃	EXAMINER?	HOSPITAL:	utpetlent 2 DOA	OTHER:	extense	a [] Oh (O)()					
Y PHYSICIAN:	27. MANNER OF DEATN  1 Neturel 5 Pending	28e. DATE OF INJUF (Month, Day, Yea	Y 28b. TIME	OF 28c.	INJURY AT WORK?	28d. DESCRIBE NOW	INJURY OCC	URED			
TED BY	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)									
COMPLET	and the same of th	SICIAN: To the best of my kr							and menner ee stated.		
띪	296. SIGNATURE AND TITLE OF CERTIFIE	Mu	na		PM50	MBER 14	29d, DATE	SIGNED	Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WI	MAOTIM	DEATN (ITEM 27) (Type,	Print)	VAN DU	oon Rd	hom	ue 1	W2-		
	JUN 2 2 1995	SE REGISTRAR'S SI									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the not have death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit, Pages be filed within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to buriat, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--	--	--

PHYSICIAN:

BY

COMPLETED

B

2

**EXAMINER?** 

1 Natural

3 Sulcide

4 Homicide

1 TES 2 NO

27. MANNER OF OEATH

Accident

Item19b 6-22-95 FilmG724 W.H.Per F/H 95 18825 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MAKGARET GRUSMAN 2:55 PM June 995 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Morth, Day, Year) AUG. 20,1918 IF UNDER 1 YEAR IF UNDER 24 HRS s. BIRTHPLACE (State or Foreign 1 - M 2 - F DAYS HOURS 217-03-5551 76 MARYLAND 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE N/A 1 K YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5103 WOOLVERTON AVE. 21215 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Merried 2 X Merried 1 TES 2 NO BY Specify: Specify: 3 Widowed 4 Divorced WHITE 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) BEAUTICIAN COSMOTOLOGY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) BE **NHOL** WEHNER ARDIE BROWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RALPH GROSMAN 5103 WOLLVERTON AVE. BALTIMORE, MD 21215 20e, METHOD OF DISPOSITION
1 Description | Method | Bernoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 4 ☐ Donation 6 ☐ Other (Specify) CHEVRA AHAVAS CHESED 6-19+1995 RANDALLSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 2121 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition\_ Obstructive Pulmonary Disease Chronic 20 years resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Artery Disease oronary COMPLETION OF CAUSE 1 TES 2 NO

OF DEATH? 1 TES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

26e. OATE OF INJURY

26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: Inpetient 2 ER/Outpetient 3 DOA

irsing Home 5 Residence 6 Other (Specify) 26b. TIME OF INJURY 28c. INJURY AT WORK? м

28d. OESCRIBE HOW INJURY OCCURED 1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)

29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated (Check only

*9	The state of the s
	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner ee stated

71	Tark	74.	Coleman	m.D.

AS2402321 MC 9816

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) June 17. 1995

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

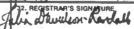
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MARK H. Coleman Sinai Hospital of Baltimore 2401 W. Belvedere MD 31. DATE FILEO (Month, Day, Year)

JUN 2 2 1995

29b. SIGNATURE AND TITLE OF CERTIFIER

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	The law requires that the death certificate be executed withing hours	
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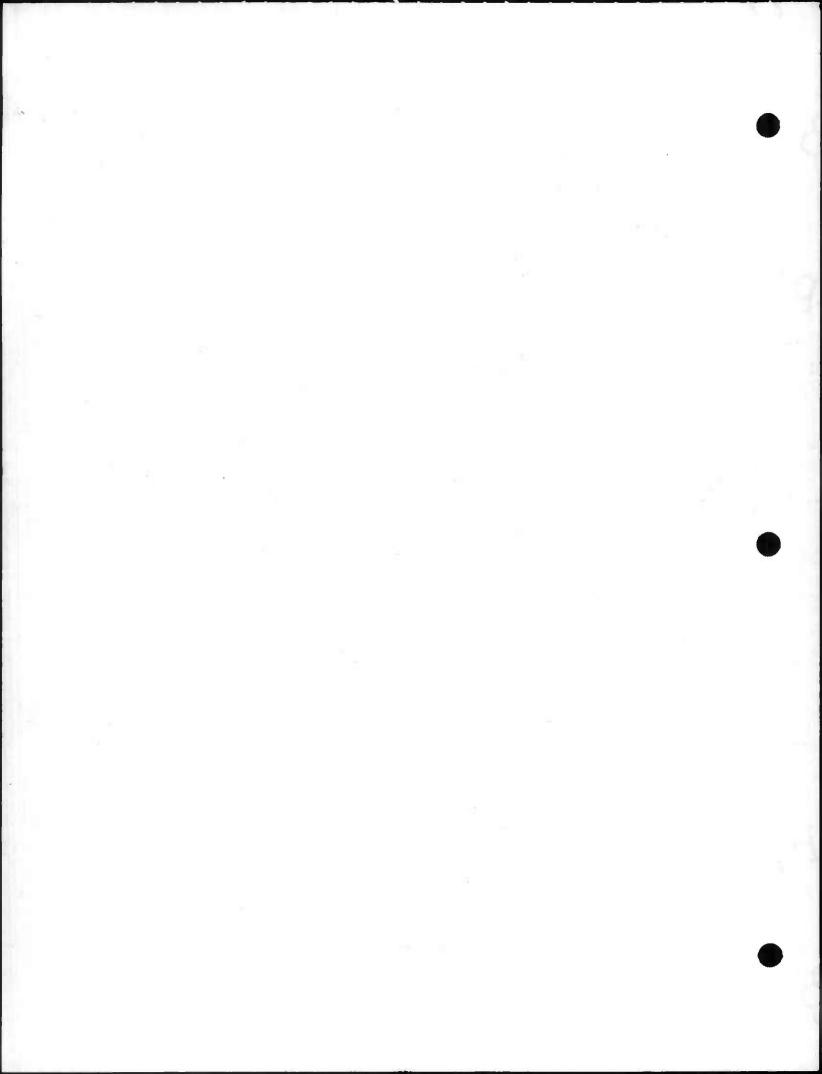
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and referred from the formal physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-	_	HEGISTRAH	U	EKITFI	CALE	OF	DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)  CLEOTHO	HILTON				***	2. DATE OF DEATH MONTH D.	6 95	year 0600 M
		0.0 1 0 1 0 6	. SEX 6. AGE (In yrs. las	The same of the sa	IF UNDER 1		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1	BIRTHPLACE (State or Foreign Country)
- 1		21102020	0 M 2 X F 62	YRS.	KONTHS E	DAYS	HOURS MIN.		933	S.C.
	œ	99. FACILITY NAME (If not institution, give street	1 1		9b. CITY, T	OWN OF	LOCATION OF D	EATH		Y OF DEATH
	СТОВ	RESIDENCE OF DECEDENT	spital				AIN		bai	HIMORU
	DIREC	10e. STATE 10b. COUNTY	1/A		TOWN OR					10d. INSIDE CITY LIMITS? 1 YES 2 NO
	FUNERAL	100. STREET AND NUMBER HIS Bucker	gham Ro			101.	ZIP CODE -1 207		10g. CITIZE	EN OF WHAT COUNTRY?
	5	11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1 YES 2					NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.)	or No — 1	4. RACE — American Indian, Black, White, etc.
	BY	3 Widowed 4 Divorced	IF YES, OIVE WAR OR DATES		10	YES :	NO Specif			Black
	E	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted) (G	CEDENT'S U live kind of wo Do NOT use	rk done due			16b. KIND OF BU	1	STRY
60	COMPLET	8th grade	NR SI	ver	fin	15	ner	Met	al	
	BE CO	17. FATHER'S WAME (First, Middle, Last) Walter Wec	Ks				Mas.	SOUVI	Brov	vn
notifie	10	Willie G. Hil	ton "	HILINO A	BLLC	V.	d Number or Rural	Route Number, City or Tow	n, State, Zip C	111 210.0
must be		20e, METHOD OF DISPOSITION 1 № Burlel 2 □ Cremetion 3 □ Remove 4 □ Donation 5 □ Other (Specify)	from State cemetery, cre	AND DATE OF	er placa)	ON (Nan		12-21-94 C		ly or Town, State
iner		21. SIGNATURE OF FUNERAL SERVICE LICENS		JOHN.			ADDRESS OF FA	CILITY	1705	0.0.
the medical examiner	j	· Nala T	March		143 W0	urdr 300	waba Waba	sh Arc		
edica		23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line.  Approximate interval Between								
the m		IMMEDIATE CAUSE (Finel disesse or condition	CARCHINA	- 00	) * A.C.			01.11 10-		Onset and Death
	1	resulting in death) s	CARCINOMA O DUE TO (OR AS A CONSE		-EROT	1 V	VITH 15	KAIN MET	ASTAS	ES
or other traumatic event,	z	b.								į
anma	AT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF):						
her t	딘	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	DUENCE OF):					_	
	CERTIFICATION	resulting in death) LAST								
31		PART II. Other significant conditions c	ontributing to deeth but not r	esuiting in	the unde	erlying	ceuse given in			24b. WERE AUTOPSY FINDINGS
	EDICAL	SE12 YRES						PERFOR	0	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ě	Σ∥								(	1 YES AD NO
23	Ä	DID TOBACCO USE CONTRIB		TH YES			UNCERTAI	ND		
r item	SICIAN	EXAMINER?	OSPITAL:    Inpatient 2   ER/Outpatient 3		OTHER:		5 🗆 Residence	8 Other (Specify)		
	PHY	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (	RY	Bc. INJUI WOR	RY AT K?	28d. DESCRIBE HOW I	NJURY OCCU	RED
S is m	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At ho building, atc. (Specify)	me, term, str				281. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,
64										
IMPORTANT: If item	COMPLET		N: To the bast of my knowledge, de On the basis of examination end/or i							
2	8	29b. SIGNATURE AND TITLE OF CERTIFIER	1 and lw				29c, LICENSE NUI	ABER 777	29d. DATE S	SIONED (Month, Day, Year)
	2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITE				231	40		PI (J
		C. RAVI, M 31. DATE FILED (Month, Day, Year)	1) NHZ /	SALT	10.	M	02113	33		
		JUN 2 2 1995	Julia Studyark	arbill						
										DHMH-16 Rev 1/89





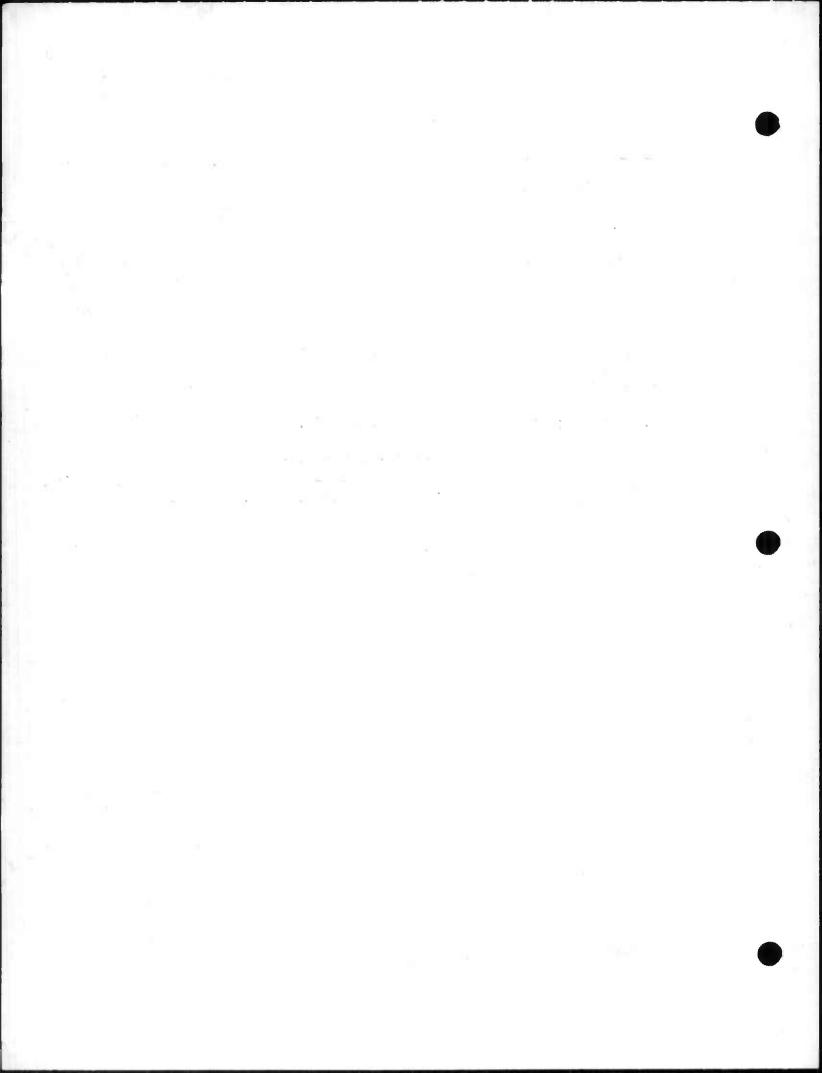
	1.0	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H		MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER	Harris	SR.			June 19		- 423 PM	
pino		257-34-8308  98. FACILITY NAME (If not institution, give s	1 ☑ M 2 □ F	(In yrs. last birthday) 7268 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	JAN . 8, 192	927 ÅL	TINPLACE (State or Foreign untry) ABAMA	
1, 2, 3 should	DIRECTOR	LEVINDALE	· · · · · · · · · · · · · · · · · · ·	IOME	BALTI		ITY	9c. COUNTY OF	i/a	
permit. Pages		MARYLAND  100. STREET AND NUMBER	n/a	10c. CIT	BALT I	MORE			10d. INSIDE CITY LIMITS? 1 XXYES 2 NO	
transit	FUNERAL	804 BONAPA	RTE AVENUE	NII C AGMED		ZIP CODE 212		UNITED		
9 2 2	ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 JNO	If yes, sp		NIC ORIGIN? (Specify Ye an, Puerto Rican, etc.) fy	В	ACE — American Indian, ack, White, atc. secity: BLACK	
	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	usual occupation work done during mose retired.)	st of working		OWNS		
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) ED HARRIS		341	C3PC1 3011	18. MOTHER'S NA	ME (First, Middle, Maiden  CE FOSTER	Sumame)	ANY	
	TO B	190. INFORMANT'S NAME (Type/Print)  EARLEASE HA	RRIS	19b. MAILING 804		nd Number or Rural	Route Number, City or Tow /ENUE, BALT	vn, Stete, Zip Code)	D 21218	
OR DECTOR DE		20e. METHOD OF DISPOSITION  W.XBurlel 2 Gremation 3 Removes from State  4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, compagny or other place)  ARBUTUS MORIAL PARK 6-24 ARBUTUS ,MD  21. SIGNATURE OF FUNETIAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY								
a safe	Ц	> tranc	PA	2	WM.	C. MARC	CH FH110		ORTH AVENUE	
his mours hely filled in bration, or rer		IMMEDIATE CAUSE (Finel	a. A CV +C DUE TO (OR AS A	each line.	2			iratory erreat,	Approximate Interval Batween Onset and Death	
P.O. BOX 687 h certificate be execute anding physician and co Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A  Chron's  DUE TO (OR AS A  A A Hero	Obstr	where	pulmos	romy di.	seace - disa	2ap	
RECORDS  v requires that the been signed by the t, of Health and M shows any Injt	MEDICA	PART II. Other algoriticant condition  multiple dead  Congestive heart  DID TOBACCO USE CONTI	failure, H	ercho vas	aula ac	ident	PERFO	RMED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
F 99 5	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:	26. PLACE OF DEA	OTHER:	e 5 🗆 Residence	8 Other (Specify)			
The state of the control of the cont	ву рн	27, MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1 U	RK? /ES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCURED		
ATTEN ATTEN ECTOR: s after 28 h	ETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, :	street, factory, office		281. LOCATION (Street City or Town, State		al Route Number,	
Z 72 =	COMPL	one) 2 MEDICAL EXAMINE	CIAN: To the best of my know R: On the bests of examination						e(a) and manner as stated.	
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT:	BE	29b. SIGNATURE AND TITLE OF CERTIFIER  Consult  A	Trans m			29c. LICENSE NU	MBER 1907	29d, DATE SIGN	ED (Month, Day, Year)	
	TO	30. NAME AND ADDRESS OF PERSON WHO CONSUELD ALVA	DEE MY	ATH (ITEM 27) (Types 2434 Ba	eto M	Belve	21217	ve '		
N		"JUN 2 "2" 1995" Ju	3 REGISTRAR'S SIGN	ATURE						

DIVISION OF

BALTIMOF	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within EA hours after death. Page 6 m	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT If Hem 28 is marked or Hem 23 shows any injury or other traumatic event, the medical avantane muse
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	e dea	Nenta	And
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	HOSP	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after cleath with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT
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	FOR	CTATE OF MADV	AND / DEDAO	T		1	90	10020
	1 - STATE REGISTRAR	STATE OF MARYL		IMENI OF HEAL		NTAL HYGIEN REG. NO	_	
	1. DECEDENT'S NAME (First, Middle, Last)	Casimir B	ernard He	pner	2	DATE OF DEATH DO THE THE DEATH DE	1995	YEAR 2:30 A
	4. SOCIAL SECURITY NUMBER  213~18~3265	1 × M 2 □ F 7.	(In yrs. lest birthday) 4 YRS.	IF UNDER 1 YEAR IF U MONTHS DAYS HOU		DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)  Maryland
PO	9a. FACILITY NAME (II not institution, give a 2433 Plainfield			96. CITY, TOWN OR LO	cation of DEATI		9c, COUNT	of DEATH Limore
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  Maryland	Baltimore	toc. City	, TOWN OR LOCATION	Dunda	ılk		10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 2433 Plainfield			101. ZIP (				n of what country?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 1 YES IF YES, OIVE WAR OR D	2 NO	If yes, specify (	NT OF HISPANIC Cuben, Mexican, F	ORIGIN? (Specify Yes Puerto Rican, etc.)		I. RACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)	CATION ocompleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us	USUAL OCCUPATION rork done during most of we retired.)		16b. KIND OF BUS		STRY
OMP	7 Years 17. FATHER'S NAME (First, Middle, Lest)		FULLA	-		(First, Middle, Malden	Indus	ory
BE C	Martin Hepner				Magdaler	re lunkn	own)	
2	190. INFORMANT'S NAME (Type/Print)	- 4:		ADDRESS (Street and Nu				
	Mr. Martin Hepn  200. METHOD OF DISPOSITION NO. Burtal 2 Cremetion 3 Parm	200	PLACE AND DATE	Gankord Ct.				27 084 y or Town, State
	4 Donation 5 Other (Specify)		netery, cremetory or of acred Ht.	of Mary Co	m. 6/21	195 Du		
	21. SIGNATURE OR PURPLE LICE LICE	E Ken	el.	Duda-Ru	oress of facili ick Fune	TY	of Du	ındalk, Inc.
	23. PART I. Enter the dispases, or a shock, or heart falluse.	Complications that coused List only one cause on a	d the death. Do n	ot enter the mode of	dying, such a	a cardiac or reapi	ratory arrea	t, Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	900	TITL- 0:	in im				Onset and Death
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	1: /				ENOUL
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):							
ERT	resulting in death) LAST	d						
MEDICAL C	PART II. Other algolificant condition	a contributing to death b	out not resulting i	n tha underlying cau	se given in Par	1 U YES 2	MEO?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
. ME	DID TOBACCO USE CONTI	DIBLITE TO CALISE C	E DEATH VE	с П но П н	NCERTAIN (			1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		INCERIAIN	74		
YSIC	1 TYES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outs	patient 3 DOA	OTHER: 4   Nursing Home 5	Residence 8	Other (Specify)		
ВУ РН	27. MANNER OF DEATH  Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	M t YES	2   NO	d. DESCRIBE HOW I		
ETED							Rural Route Number,	
COMPLETED		CIAN: To the best of my know						euse(s) end manner eg stated,
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		LA.		LICENSE NUMBER			ONED (Month, Day, Year)
10	30. NAME AND ADDRESS OF BERSON WH  Y'L CONTROL WENT  31. DATE FILED (Month, Day, Mar)	O COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type,	Print) 40 Editer	an	BAY 11.	or ky	121224

31. DATE FILED (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

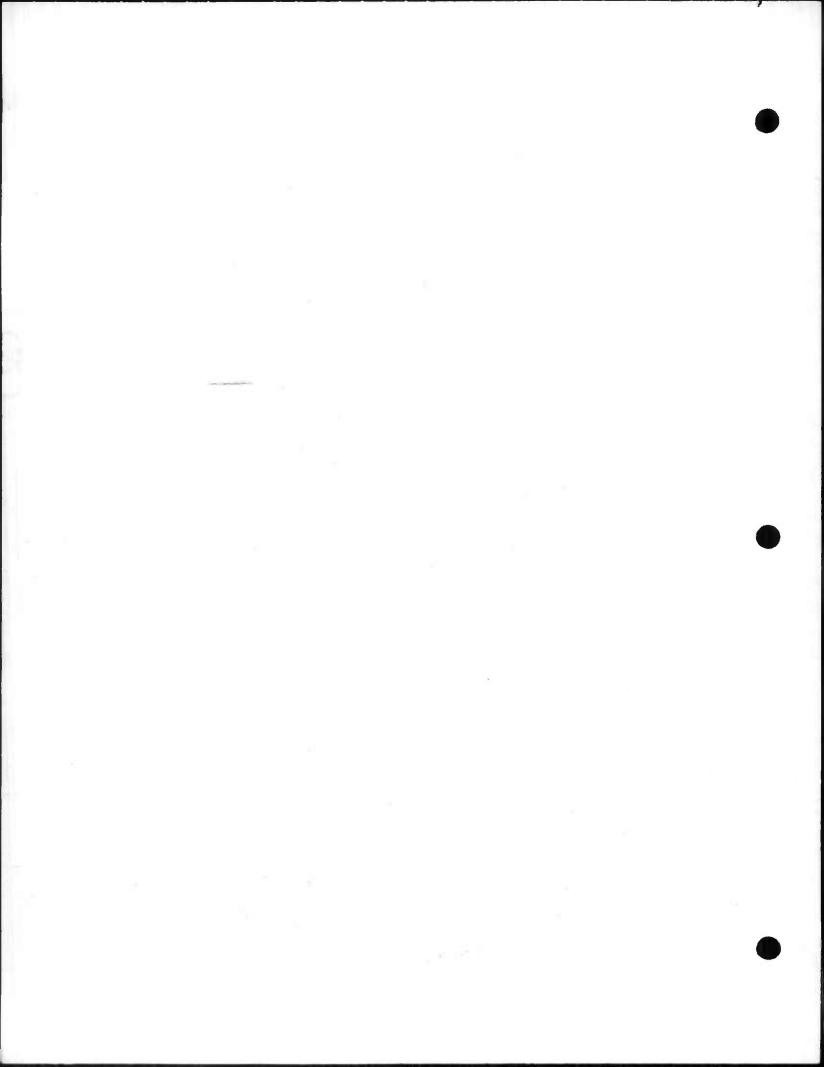
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.								
1	1. DECEDENT'S NAME (First, Middle, Last)				2. 0	ATE OF DEATH			3. TIME OF DEATH
	Gertrude Veron	e Veronica Hess June 16,							1:15a w
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR F UNDER 24 H		ATE OF BIRTH	- 1	. BIRTH	PLACE (State or Foreign
	058-03-0928  9a. FACILITY NAME (If not institution, give	1 □ M 2½□ F 8:	3 YRS.		Au	g.7,19		vew	York
E E	955 Cedar Grov		1	b. CITY, TOWN OR LOCATION ( Edgewater	OF DEATH		9c. COUNT		rundel
SCTC	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT				-		Aime	; A.	Lunder
DIRECTOR		Arundel		rown or Location water					10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	10e. STREET AND NUMBER			101. ZIP CODE				EN OF W	HAT COUNTRY?
FUNERAL	955 Cedar Grov			21037			USA		
FU	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF H If yes, specify Cuban, M	ISPANIC OR	HGIN? (Specify Yes	or No- 1	4. RACE Black	- American Indian, White, etc.
B≺	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES		Specify:	,		Specif	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION	16a. DECEDENT'S US	UAL OCCUPATION k done during most of working		16b. KIND OF BUS	SINESS/INDU	STRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Housewi	etired.)		0.	n Hoi	m =	
MP	8 17. FATHER'S NAME (First, Middle, Last)		Housewi					lie_	
BE CC	Richard McBrid	le		Gertr	ude ude	rst, Middle, Malden Rooney	Surname)		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO AL	DDRESS (Street and Number or F	Rural Route I	Number, City or Town	n, State, Zip C	ode)	
	Susan CAssidy		955 Ce	dar Grove	Ave.	Edgew	ater	, M	D 21037
	20s. METHOD OF DISPOSITION  Disposition 3 - Ren	noval from State	PLACE AND DATE OF	place)	1		CATION — CH		
	4 Donation 5 Other (Specify)	ICENSEE / P	inelawn	Cemetery	E EACH ITY	/19 Fa	rming	gda	le, NY
	1 80H 1	(11/1)		Hardesty			me, E	. A	
$\dashv$	23. PART I. Enter the diseases, or	1001		12 Ridgel	ν Δ ν	enne	Annar	001	
	anock, or neert failure.	List only Dne ceuse on ea	nch ilne.	enter the mode of dying,	auch as	cardiac or reapi	ratory arrea	it,	Approximata intarval Between
	IMMEDIATE CAUSE (Finel disease or condition	Mater	1: 10	Accion change					Several
	reaulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	runoma					months
N	Sequantially list conditions,	b							
ATIO	if any, laading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF):						
FIC	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST	d							
	PART II. Other algnificant condition	na contributing to deeth be	ut not resulting in	the underlying cause give	n in Dart i	. 24s. WAS AN	AUTORON	100	
MEDICAL	Total Control of Contr		at not readiting in	the underlying cause give	n in Pari	PERFOR	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
밀						1 TES 2	No		OF DEATH?
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □ UNCER	TAIN X	1			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	Check only one)					
YSI	1 VES 2 NO	HOSPITAL: 1   Inpetient 2   ER/Oulp		THER:  Nursing Home 5 Reside	nca 6 🗆 C	Other (Specify)			
	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIME C	Y WORK?		DESCRIBE HOW IN	NJURY OCCU	RED	
В	2 Accident Investigation M 1 YES 2 NO								
TED	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, fectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							oute Number,	
PE	29a. CERTIFIER (Check only Check only 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated.								
ŏ.	29a. CERTIFIER (Check only one)  2   MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated.								and manner as stated.
BE C	296. BRANASHIRE AND TITLE OF CENTIFIE	1/.		29c. LICENSE	NUMBER	0.0	29d. DATE S	IONED (	(Month, Day, Year)
TO E	(Maries VI, X	me		100	59	18	Du	me	16,1995
	30. NAME AND ADDRESS OF PERSON WI	Kinzaw (		0-1-	Dr	ive. An	100 0	1.	NAD 214AI
	JUN 2 2 1995	2. REGISTRAP SIGNA		JII TOTES	עו	IVE, M	napo	115	, IVIY LITU
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND		GIENE G. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH
		HERMAN  4. SOCIAL SECURITY NUMBER	L.	JONES	Jr.	· · · · · · · · · · · · · · · · · · ·	June	13, _	1995	7:35 a
22	Œ	220-36-1594	1 ₹ M 2 □ F	(In yrs. last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIF (Month, Day, Feb. 5	TTH Year) 5, 1941	Country)	PLACE (State or Foreign ) Cyland
pyroug		9a. FACILITY NAME (If not institution, give				OR LOCATION OF D	EATH	9c. CO	UNTY OF DE	ATH
1. 2. 3	디	5002 Ivanhoe Aver	nue		Balt:	imore			N/A	- 2
	ш	10a, STATE 10b, COUNT		10c. CIT	Y, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
permit. Pages	DIR	MD 100, STREET AND NUMBER	N/A	E	Baltimore					1 X YES 2 NO
isit	TO BE (	5002 Ivanhoe Av	venue		10	21212		11.0	S.A.	HAT COUNTRY?
Z I S-UUZU attending physician. se as the burial-transit		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	II yes, sp	CENDENT OF HISPAL pecify Cuban, Maxico 3 2 NO Specif	nn, Puerto Rican,	cify Yea or No— etc.)	14. RACE Black, Specify	- American Indian, White, etc.
		15. DECEDENT'S EDU (Specify only highest grade	completed)		USUAL OCCUPATE work done during me		16b. KIND	OF BUSINESS/IN	DUSTRY	
by the hospital or be detached for u		Elementary/Secondary (0-12) 6th	College (1-4 or 5+)		k Mason		C	onstruc	tion	
		17. FATHER'S NAME (First, Middle, Last)  Herman Jones, S	Sr.				ME (First, Middle,			
		19a. INFORMANT'S NAME (Type/Print)	)L •	19h MAII (NG	ADDRESS /Street	and Number or Rural	Beaker	_		ie –
death. Page 6 may be re funeral director, page 5 examiner must be no		Herman Lee Jone	es III			Street/				Į.
		20a. METHOD OF DISPOSITION 1 M Buriel 2 Cremation 3 Rem	206	PLACE AND DATE	OF DISPOSITION (N			20c. LOCATION -		
		4 Donation 6 Other (Specify)	M1	calvai	cy Cemet			Anne Ar	undel	Co, MD
		21. SIGNATURE OF FUNERAL SERVICE LI	Scene		March	NO ADDRESS OF FA TENORED	Homes	East /Raltim	ore.	MD 21202
ed within 24 hours aft completely filled in by al. cremation, or remo	NC	23. PART I. Enter the diseases, or ahock, or heart feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions,	a. Reval  DUE TO (OR AS A	d the death. Do lach line.  for a consequence of the consequence of th	lure sur	ode of dying, suc	ch as cerdiac or	r reapiratory as	rreat,	Approximate Interval Between Onset and Death 5 years
th certificate be ending physician I Hygiene prior to or other traus	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c. DUE TO (OR AS A	A CONSEQUENCE O	F):					
w requires that the dear is been signed by the att pr. of Health and Menta 3 shows any injury,	MEDICAL	3/7 500	auch Kt	enal 7.	yans	play	<b>✓</b> ⊸   <sup>F</sup>	NAS AN AUTOPSY PERFORMED? YES 2 10		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?  1  YES 2 NO
1 2 8 8 2 N	AN:	DID TOBACCO USE CONT	RIBUTE TO CAUSE C			UNCERTAI	N Z			
N: The faw icate has b State Dept.	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 M/ES 2   NO	HOSPITAL:	26. PLACE OF DEA	OTHER:	N/				
HYSICIA this certif with the feed, or	PHY	27. MANNER OF DEATH  1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. INJ	NA 5 Rasidence		HOW INJURY OC	CURED	
STOR: A after da after da 15	TED BY	Accident Investigation  Suicida 6 Could not be datarmined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, :			28f. LOCATION City or Town	(Street and Number, State)	or Rural Ro	ute Number,
TAL OR AL DIRI 72 hour	COMPLET		ICIAN: To the best of my know							
HOSPITAL FUNERAL Within 72 TTANT: If		296, SIGNATURE AND TITLE OF CENTIFIE		CA11-	A spanion, o				-	
TO THE HOSPI TO THE FUNER De filed within	O BE	(26)	D8V-6	Ble 18	reca	D44	810	29d. DA	TE SIGNED (A	Month, gey, Year)
		30. NAME AND ADDRESS OF PERSON WH	OCCOMPLETED CAUSE OF DE	ATH (ITEM 27 (Type,	Print)	ו וענייר	,		11	1
3		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE OU	ul 2	20, 1	Mu	rock	1 10	spury



**MARYLAND 21215-0020** BALTIMORE, hours after death. O. BOX

DIVISION OF VITAL RECORDS,

permit funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. notified a 9 examiner the state of medicai completely filled in by the the death certificate be executed within 24 traumatic event. and com 2 attending physician mal Hygiene prior to other 1 9 Mental injury. the been signed by the requires that shows any has be Dept. OR ATTENDING PHYSICIAN: The law tem certificate the State

Pages 1, 2, 3 should

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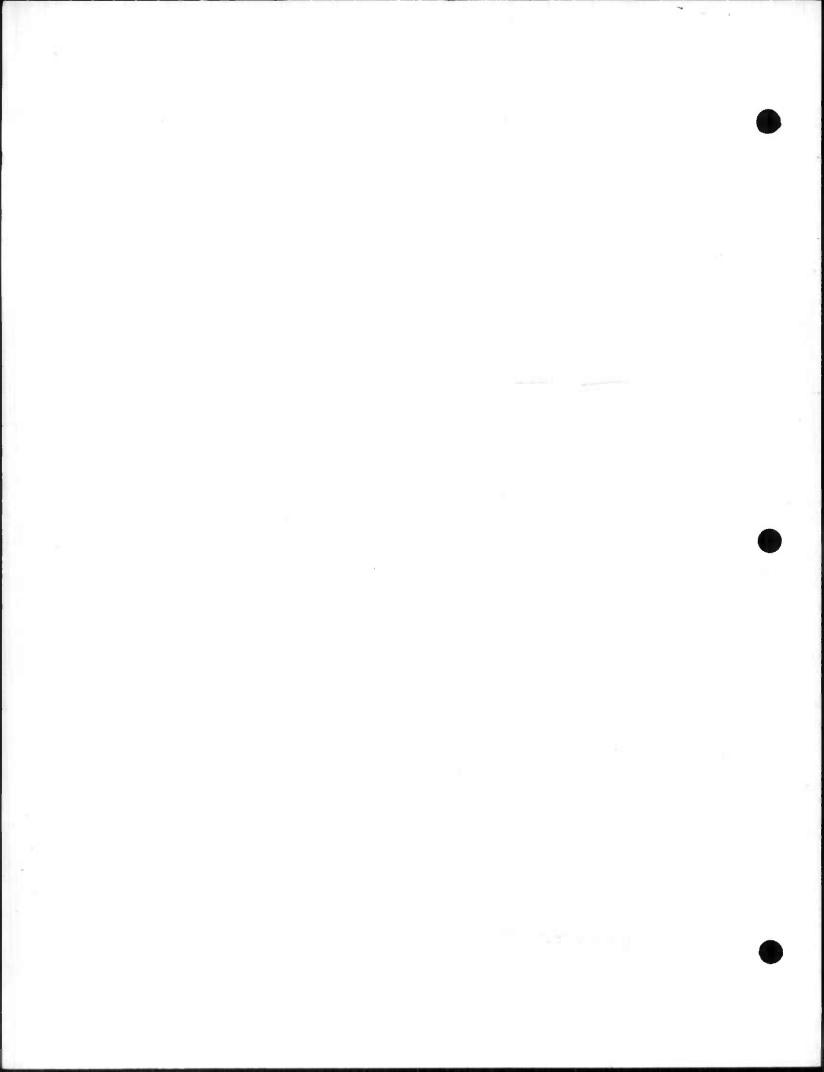
once.

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must

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF GEATH 3. TIME OF DEATH **EDWARD** BICKEY SR. **JOHNSON** JUNE 21 1995 4:55A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) MAR . 15, 1918 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 220-05-9891A BALTO., MD 1 XX 2 - F 77 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1007 VALLEY STREET 21202 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yea, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American indian, Black, White, etc. 1 Never Married 2 Merried FORCES? 1 YES 2 NO Specify: BLACK 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) tary/Secondary (0-12) College (1-4 or 5+) TH WAITER ENGINEER SOCIETY 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle Maiden Surry -ONHOG DANIEL JOHNSON ETHEL BROWN 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) ZELMA **JOHNSON** 1007 VALLEY STREET, BALTIMORE, MD 20s. METHOD OF DISPOSITION
X & Burlel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE MEMOR IAL 4 Donetion 5 Other (Specify) GARDENS 6-26 DUNDALK, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel **Onest and Death** disesse or condition\_ SEPSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF NTEROBACTER Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Bonn DUE TO (OR AS A CONSEQUENCE OF thet initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 10 OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA Nome 5 Reeldence 5 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural INJURY 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) '8 Could not be 4 Nomicide 29e. CERTIFIER (Check only one)

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(a) end memor se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) June 21, 1995 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) JOHNS HOAKING DAMP F. Kome Tower 110 EMTIMOR HOSATAL 32. BEGISTRAR'S SIGNATURE
Julia dhuulson Randall



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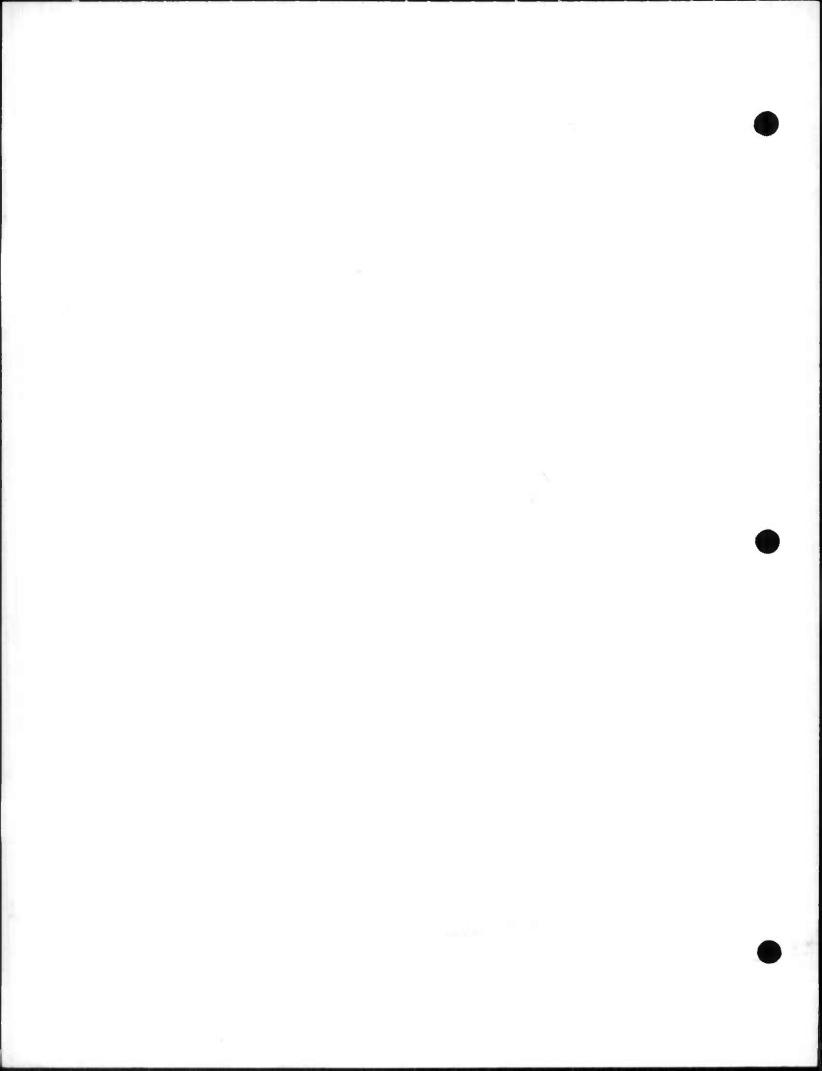
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH A	ND MENTAL HYGIENE
CERTIFICATE OF DEATH	H REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPAR CERTIFI	MENT OF H	EALTH AND I	MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)  Vernon C. Lit					2. DATE OF DEATH	DAY 19	YEAR	TIME OF DEATH
	705-09-7427	XX M 2 □ F 8	lest birtnday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dev. Year)		8. BIRTHPL Country) MARYL	ACE (State or Foreign
DIRECTOR	90. FACILITY NAME (If not institution, give street and number)  Union Memorial Hospital  Baltimore City  N/							N//	
EC	10a. STATE 10b. COUNTY			TOWN OR LOCAT	ION			10	id, INSIDE CITY
	MARYLAND N/A			BALTIMOR Too	E CITY		10g. CITtZ		LIMITS?  (X) YES 2   NO
FUNERAL	2327 N. DUKELAND S	TREET			21216		U.5	S.A.	
COMPLETED BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED NO	IED 13. WAS DECENDENT OF HISPANIC ORIGIN?  If yes, specify Cuban, Mexican, Puerto Ric  1 ☐ YES 2 ☒ NO Specify:		n, Puerto Rican, etc.)	Rican, etc.) Black, White Specify:		American Indian, Vhite, etc.
		TION mpleted) 16e College (1-4 or 5+)		JSUAL OCCUPATIO ork done during mo- retired.)		16b. KIND OF I	BUSINESS/IND		DLACK.
MP	11th grade	T	RACKFO	REMAN		UNK	NOWN		
E CO	17. FATHER'S NAME (First, Middle, Last) ROBERT LINGHAM					ME (First, Middle, Maid	en Sumeme)		
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AODRESS (Street a		LINGHAM Route Number, City or 1	own, State, Zip	Code)	
5	ELSIE M. LINGHAM					T. BALTIM			
	20s. METHOD OF DISPOSITION    Buriel 2   Cremetion 3   Remove   Donation   Company   C	al from State 20b. PLA	CE AND DATEO	FDISPOSITION (Na DELACE) PALAL PA	me of D V		ODLAWN		
1	21. SIGNATURE OF PUNERAL SERVICE LICEN		NO PILM	22. NAME AN	O ADDRESS OF FA	CILITY			TLAND
	Maken A.	62		1206	W. North	OWN COMMU			
,	IMMEDIATE CAUSE (Finsi	nplications that caused the strong one cause on each  DUE TO (OR AS A COM	line.	ot enter the mo-	ds of dying, suc	h as cardiac or rec	piratory srre	est,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, b.	DUE TO (OR AS A CONDUE TO (OR AS	bsces		nerof	Righty	oper la	he	7 days
PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to deeth but n	ot reculting in	the underlying	ceuse given in	Part I. 24a. WAS PERF	AN AUTOPSY ORMEO?	CO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION DF CAUSE DEATH?
AN:	DID TOBACCO USE CONTRIE			NO 🗆	UNCERTAIN	<u> </u>			
SICI/		26. P IOSPITAL: Inpatient 2 ER/Outpatien		(Check only one) OTHER:	. C B . H				
ву РНҮ	27. MANNER OF DEATH  1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. INJURY WO	JRY AT	8 Other (Specify)  28d. DESCRIBE HOW	Y INJURY OCCI	URED	
- 10	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 26e. PLACE OF INJURY — At hom building, etc. (Specify)					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			e Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:	IN: To the best of my knowledge On the bests of exemination and	, death occurred	f at the time, data	and place, and due	to the cause(a) end n	nanner as atate	od. s cause(s) er	nd manner as stated.
BE	286. SIGNATURE AND TITLE OF CENTIFIER	wy men	1 1	nn	29c, LICENSE NUM				onth, Day, Year)
2	SAMUEL MALL				11	,	1	1	, -1 . ( )
	31. DATE FILED MOZE 1995 Jal	32 FOIS TAR'S NATE	nin M	emerical	Hospik				8
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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTORS After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit or the funeral director, page 5 should be detached for use as the burial-transit or the funeral director, page 5 should be detached for use as the burial-transit	be men within 12 hours after death with the State Cept. Or health and wested mysteme prior to collect, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Elizabeth Charlotte Lauman lune 19 1995 10:25 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (MONTH, Day, Mar) Jan. 15, 1928 IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State 1 🗌 M 2 🙀 F DAYS HOURS Maryland 213-26-4329 67 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH The Johns Hopkins Hospital Baltimore City Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore County 1 ☐ YES XX NO 10a STREET AND NUMBER 10t. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21234 USA 3302 Garnet Rd. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES XXNO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES XXNO 1 Never Married 2XX Merried Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EQUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) Beltway Electric Co. N/A Secretary 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Frank Swagler Elizabeth Dieter 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Lauman 3302 Garnet Rd. Baltimore, Md. 21234 200. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 3 Burlel 2 Cremation 3 Rem
4 Donation 5 Other (Specify) Gardens of Faith Cemetery 6-22-95 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home Long - The 7401 Belair Rd. Baltimore, Md. 21236 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition neumonia week resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE O)): Leukemia 1 month Acute Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING Ovarian Cancer years CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? CANCER Breast 1 TES 2 NONO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO Inpetient 2 ER/Outpetient 3 DOA ng Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) and manner se stated. 296. SIGNATURE AND JITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1995 M620 S OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated.

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Yamamoto MD

Joshua

(Check only one)

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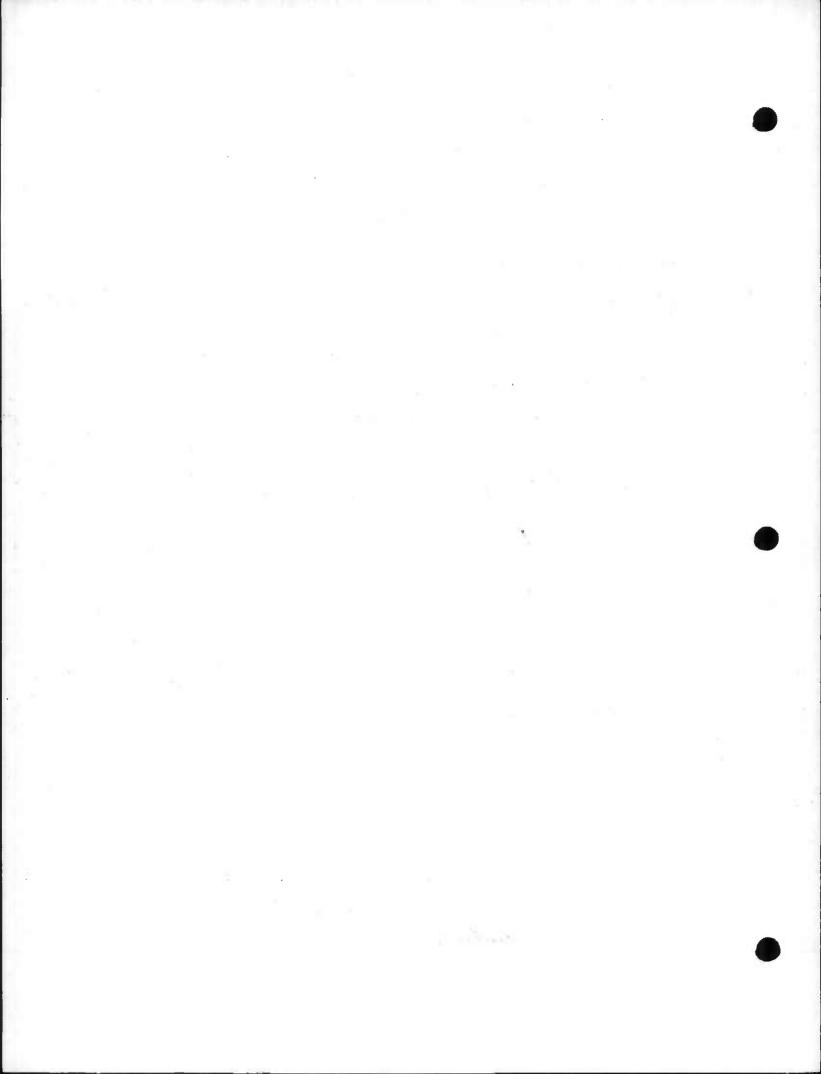
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JUN 2 2 1995

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Leat) Charles C. Lynde Jr.  2. Date of DEATH MONTH June 18,1995 3. Time of DEATH 12:30a							
	4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. last birthdey)  1 X M 2 F  74  YRS.  6. AGE (In yrs. last birthdey)  F UNDER 1 YEAR  IF UNDER 24 HRS.  7. DATE OF BIRTY  (Month, Dey. Year)  Aug 2 2 1920  Ohio							
FUNERAL DIRECTOR	98. FACILITY NAME (If not institution, give street and number)  5703 Shore Road  99. CITY, TOWN OR LOCATION OF DEATH Churchton  90. COUNTY OF DEATH Anne Arundel							
	10a. STATE 10b. COUNTY  Maryland Anne Arundel Churchton 10d. INSIDE CITY  LIMITS?  1 Od. INSIDE CITY  LIMITS?  1 Upes 2 Upo							
	100. STREET AND NUMBER  5703 Shore Drive  101. ZIP CODE  20733  USA							
BY	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 NO  15. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  16. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  17. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  18. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  19. Was DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  10. Was DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)  11. Was DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-Black, White, etc.)							
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  12  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.)  Sheet Metal Worker  Steel							
BE COM	17. FATNER'S NAME (First, Middle, Last)  Charles C. lynde Sr.  18. MOTNER'S NAME (First, Middle, Maiden Surname)  Lydia Ann Hildebrand							
TO 8	196. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Francis H. Lynde  Wideveiw Rte. 4, Chattanooga, TN 37409							
	206. METNOD OF DISPOSITION    Dariel 2   Cremetton 3   Removal from State							
	Hardesty Funeral Home, P.A.  12 Ridgely Ave. Annapolis, MD 2140  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, Approximate							
	ahock, or heart failure. List only one ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Acute Caydo Respiratory 741/47 e  Due to (or as a consequence of):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.							
MEDICAL	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO  24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO							
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO OTHER: 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify)							
ву РНУ	27. MANNER OF DEATN  1 Neturel 5 Pending 2 Accident Pending 1 Investigation  28e. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY WORK? 1 YES 2 NO  28c. INJURY AT WORK? 1 YES 2 NO							
LETED	3 Suicide Suic							
COMPL	(Check only One)  1 CERTIFFING PNTSICIAN: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated.  2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.							
TO BE	296. DIGOSH 296. DIES OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TOPO Print)  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TOPO Print)							

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REG. NO

2. DATE OF DEATH

FOR STATE

1. DECEDENT'S NAME (First, Middle, Last

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Arthur SUMP 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) DAYS HOURS MIN. 1 X M 2 - F YRS. 257-05-5018 92 09-08-1902 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR CHURCH HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE permit. MARYLAND. DUNDALK FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE detached for use as the burial-transit 1046 OLD NORTH POINT ROAD 21224 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☆ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 X NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 X Divorced W.W. COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comp. Elementary/Secondary (0-12) College (1-4 or 5+) CAB DRIVER 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) 2 To BE N/A N/A notified : 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 WRAY McCURDY EASTERN BLVD., BALTIMORE, page e 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 [X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must director, CHESAPEAKE CREMATORY 4 Donation 5 Other (Specify) 06-17-96 medical examiner 21. SIGNATURE OF LUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral nours after death. Cullen BRADLEY-ASHTON FUNERAL HOME, INC. completely filled in by the frial, cremation, or removal. 2134 WILLOW SPRING RD., BALT., MD 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final OUE TO (OR AS A CONSEQUENCE OF): the disease or condition\_ resulting in death) traumatic event, executed bunal, CUTE 19 40 POTEN CAI Gailwe CERTIFICATION and Sequentially list conditions, Hygiene prior to If any, leading to immediate attending physician 2 Sepsis cause. Enter UNDERLYING certificate CAUSE (Disease or injury other 1 OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST mermonia 6 the death signed by the atter Health and Mental Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY Dementiq requires that shows any 1 TES 2 NO cereboragedon accident has been to DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: AMP. Dept 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) The EXAMINER? tem this certificate h NOSPITAL: OTHER: ATTENDING PHYSICIAN: Appetient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 28a, DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, Natural M 1 YES 2 NO BY nvestigation death After Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 60 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) COMPLETED 8 Could not be DIRECTOR after 28 4 Homicide hours Hem OR 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M (Check only one) MEDICAL EXAMINER: On the ition and/or investigation, in my opinion, death occured at the time, data end place, and due to the cause(s) and manner as stated. HILE OF 29b. SIGNATURE AND 29c. LICENSE NUMBER BE 43340 2 COMPLETED CAUSE OF DEATH, (ITEM 27) (Type Sichard

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JUN 2 2 1995

MID

32. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

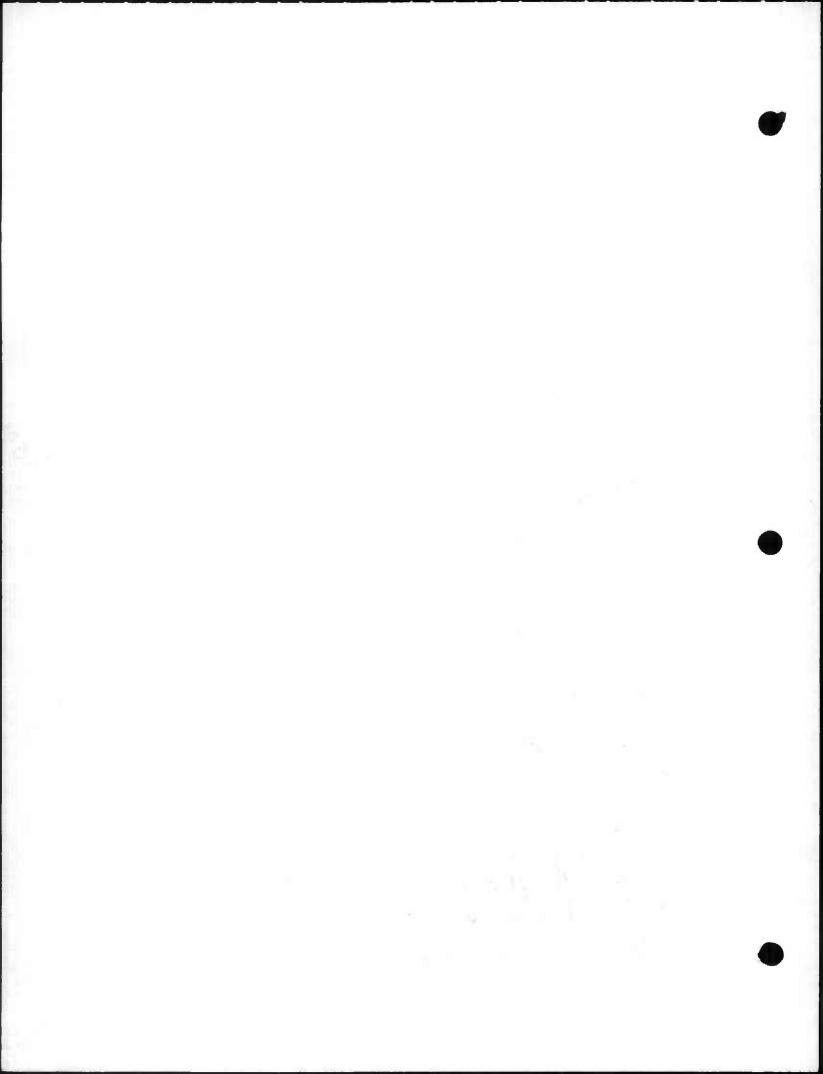
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH 99 TEAR 8:238 8. BIRTNPLACE (State or Foreign PENNSYLVANIA 9c. COUNTY OF DEATH N/A 10d. INSIDE CITY 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY CAB COMPANY MD 21221 20c. LOCATION - City or Town, State BELTSVILLE, MARYLAND 21222 Approximata Interval Betwe **Onset and Death** 

ONMH-18 Rev 1/89

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TES 2 NO

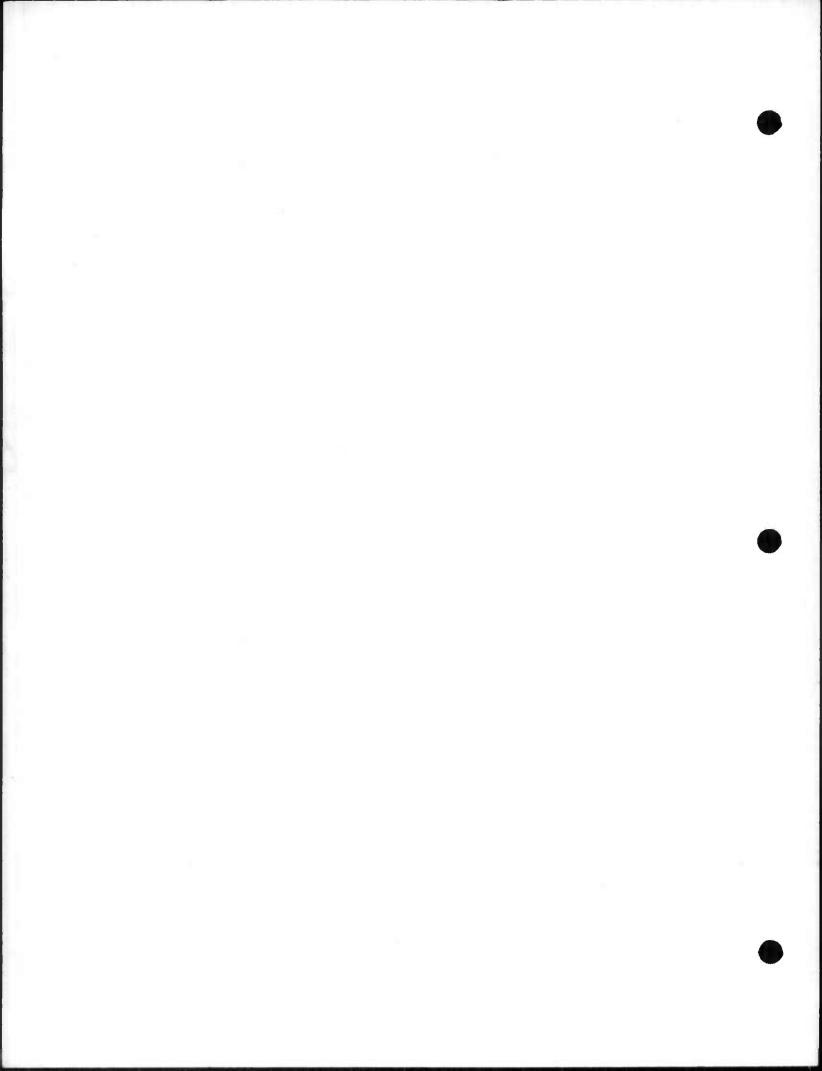
29d. DATE SIGNED (Month, Day, Year)



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ENHERAL DIRECTOR. After this certificate has been attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	prior to burnal, cremation	
SPITAL OR ATTENDING	ERAL DIRECTOR: After	IN 72 hours areer beau	
TO THE HOS	TO THE FUN	De nied wrun	

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	The state of the s	OLITTI	ICAIL OF D	ALACT I	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)  ARIEL	MCCA	LLISTER		JUNE 19,		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 5. SEX 6.	AGE (In yrs. last birthday)		F UNDER 24 HRS.	7. DATE OF BIRTH		7:12 A M		
	Q13-37-7533 10 M2 DF	2 YRS.		OURS MIN.	(Month, Day, Year)	Count	HPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give street and number)	Sept 13, 1991 M			Inq				
or.		9b. CITY, TOWN OR L		ATH '	9c. COUNTY OF C				
DIRECTOR	THE JOHNS HOPKINS HOSPITA		BALTIMORE CITY			N	A		
L	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY   10c. CITY, TOWN ON LOCATION								
<u> </u>	The Balton								
	100 STREET AND NUMBER			1 YES 2 NO					
M	100 STREET AND NUMBER  101. ZIP CODE  109. CITIZEN OF WHAT COUN								
FUNERAL	2663 DSWego Ave 212-15 U.S.A.								
5	1 Never Married 2 Merried FORCES? 1	YES 2 NO	13. WAS DECENE If yes, specify	DENT OF HISPANI 'x Cuban, Maxican	C ORIGIN? (Specify Yea, Puerto Ricen, etc.)		E — American Indian, k, White, etc.		
₽	3 Widowed 4 Divorced IF YES, GIVE WAR	OR DATES		NO Specify:		Spec	m Black		
8	15. DECEDENT'S EDUCATION	16- DECEDENT'S	USUAL OCCUPATION		Difference and a second		.5/40		
1 🗒	(Specify only highest grade completed)	(Give kind of v	vork done during most of	f working	16b. KIND OF BUS	INESS/INDUSTRY			
1 2	Elementary/Secondary (0-12) College (1-4 or 5+)	N	/A		N	1 A			
COMPLET	T. FATHER'S NAME (First, Middle, Leat)		1	ACTUENIO MAN	P. Clina Military Mariana	1			
\$ O	Leonard Mc Callis	ter	1 1	140 +	E (First, Middle, Malden S	1	_		
B H	194. NFORMANT'S NAME (Typo/Print)	10h MAU INC	ADDRESS (No. 1)	Colum	nia	lurner			
들	Cynthia Turner	4417	) a	Ma I	outerflumber, Clax or Town	A State, Zip Code)	Ito mod ZIZIS		
2	209 METHOD OF DISPOSITION DS Buriel 2 Cremation 3 Removal from State	-   -   -	4 10,101 -1-13						
examiner must be notified at once.  TO BE COM	200 READO ATE OF DISPOSITION   DATE   200 Comment   200 Co								
To He	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY								
E	11 50 - 21	1	march	h F.H	- West				
	will from	my	14300	wab	ash Ave				
medicai	23. PART I. Entar the disesses, or complications thet.o shock, or heert failure. List only one ceuse	dused the deeth. Do no on each line.	ot enter the mode	of dying, such	ea cerdiec or respir	atory arrest,	Approximate		
=	IMMEDIATE CAUSE (Final								
t, the	disease or condition resulting in death)  a. Congestive Heart Failure 48 hrs								
5	DUE TO (OF	AS A CONSEQUENCE OF	):						
or other traumatic event, ERTIFICATION	Sequentially list conditions, Sequentially list conditions, Sequentially list conditions,								
E E	the any, leading to immediate cause. Enter UNDERLYING								
5 5	CAUSE (Disessa or injury								
8 E	that initiated events resulting in death) LAST	R AS A CONSEQUENCE OF	7):				1		
	d								
3 .	PART II. Other significant conditions contributing to de	eth but not resulting i	n the underlying ce	euse given in P	Part I. 24e. WAS AN A	WTOPSY 246	WERE AUTOPSY FINDINGS		
DICAL	liver diseas				PERFORM	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE		
WED W			~ 1	0	1 D TES 2	□ NO	OF DEATH?		
2   ≥	DID TOBACCO USE CONTRIBUTE TO CAUS	- yas	Y O CACT	CTITI-		l l	1 TYES 2 KNO		
က I Z	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEAT		UNCERIAIN					
PHYSICIA	EXAMINER? HOSPITAL:		OTHER:						
1YS		R/Outpatient 3 DOA	4 Nursing Home 5	-					
	27. MANNER OF DEATH  26a. DATE OF IN. (Month, Day,	JURY 26b. TIM(	URY WORK?		28d. DESCRIBE HOW IN	JURY OCCURED			
图	2 Accident Investigation	1		2 NO					
Z8 IS	3 Suicide 6 Could not be building, atc	IJURY — At home, farm, s. (Specify)	treat, lactory, office	1	281. LOCATION (Street an City or Town, State)	nd Number or Rural I	Route Number,		
E I			_						
를 달	(Check only 1 DE CERTIFYING PHYSICIAN: To the best of my								
MPORTANT: If item 28  O BE COMPLETE	2 MEDICAL EXAMINER: On the basis of exam	ination and/or investigation	n, in my opinion, death	occured at the ti	me, deta and place, and	due to the cause(s	) and manner ea stated,		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		29	LICENSE NUME	ER,	29d. DATE SIONED	(Month, Day, Year)		
10	E, Zonowie Pediar	melsie	ent	4	5601	D 611	9/95		
1 =	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF DEATH (ITEM 27) (Type,	Print)	1 0	200				
	t- EENOWICH 14a	5 Meno	ale R	a Ba	ehmor	e, mo	21239		
	JUN 2 2 1995 Jun 2 32. RUGISTRAD'S								
	JUNG 6 1333 JUNG ON	made. APANT							



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	PAI TIMODE	ביבי	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ay be retained by the hospital or attending physician.	page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	t be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2. DATE OF DEATH

MONTH AND MENTAL HYGIENE

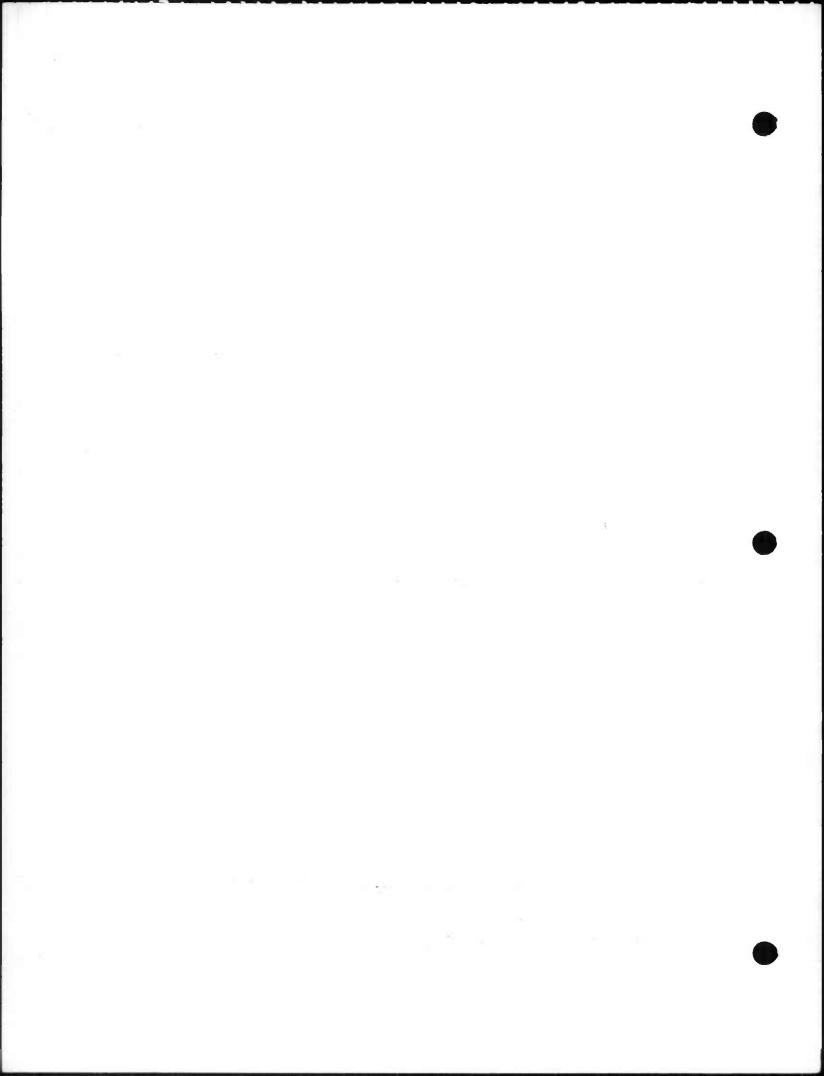
REG. NO.

2. DATE OF DEATH

MONTH AND DAY

DAY

Patrick Joseph McCaffery, Sr.  2. Date of Death Month Patrick Joseph McCaffery, Sr.  2. Date of Death Month Patrick Joseph McCaffery, Sr.  2. Date of Death Month Patrick Joseph McCaffery, Sr.									3. TIME OF DEATH A				
	4. SOCIAL SECURITY NUMBER 218-60-6817  5. SEX 1					UNDER 1 YE		UNDER 24 HRS. URS MIN.	7. DATE	7. DATE OF BIRTH (Month, Day, Veer) 6, 1939 SCOTLAND			
TOR	96. FACILITY NAME (If not institution, give street and number)  3416 O'Donnell Street  Baltimore City  9c. COUNTY OF DEATH City										ATH		
DIRECTOR	10e. STATE 10b. COUNTY Maryland N/A					own on L		City				- 1	IOd. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3416 0 Donn		reet		-		101. ZIP	21224	10g. CITIZEN OF W Scotlar			otlan	IAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Merried 2 3 Divo		12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WI	YES 2 X N	MED	AED 13. WAS DECENDENT OF HISPANIC If yes, specify Cuben, Maxicen, P 1 YES 2 X NO Specify:			n, Puerto	, Puerto Rican, atc.) Black, W			American Indian, White, etc.
百	(Specify onl	EDENT'S EDU ly highest grade	CATION completed)	(Gi	CEDENT'S US	done during		working	166	. KIND OF BUS	SINESS/INC	DUSTRY	
PLE	Elementary/Secondery (6	0-12)	College (1-4 or 5 +)		on NOT uso re		Cond	dition		Self-E	mplo	ved	
COMPLETED	17. FATHER'S NAME (First, M William McC		/	11000	7211G &	7122		MOTHER'S NAI	ME (First,		Sumame)		
TO BE	190. INFORMANT'S NAME (1) Elizabeth M		ery					umber or Rural F		ber, City or Town			
	20e. METHDO OF DISPOSIT  1	on 3 🗌 Rem	oval from Stata	20b. PLACE	AND DATE OF D	ISPOSITIO	N (Neme of		DAT	E 20c. LO	CATION —	City or Tow	
	21. SIGNATURE OF FUNERA		CENSEE	Tareen	MOUNT	22. NAM	E AND A	DDRESS OF FA	CILITY_		-	C, 140	iryrana
	- 1	elier	th se	lins	RC	700	Ly & S. (	Zeilei Conklir	r, Ir ng St	nc. Fur .,Balt	neral timor	e, ME	21224
23. PART I. Enter the disasses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory strest, shock, or heart failure. List only one cause on each line.								Approximata Interval Between					
IMMEDIATE CAUSE (Fine) disease or condition  Respire days								Onset and Death					
Ì	IMMEDIATE CAUSE (Fine)  disease or condition resulting in death)  Due to (or as a consequence of):										1/100		
NOI		Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										1/2 years	
ICA	cause. Enter UNDERLY	ING	C	OR AS A CONSEC	NIFILE OF								
CERTIFICATION	that initieted events reaulting in death) LAS	т	d	ON AS A CONSEC	DUENCE OF):								
	PART II. Other aignifica	int condition	e contributing to	leeth but not re	eeuiting in t	he under	lying cau	uee given in	Part I.	24s. WAS AN			VERE AUTOPSY FINDINGS
MEDICAL									_	PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
11	DID TORACCO II	ICE CONIT	DIDLITE TO CAL	ICE OF DEA	TIL VEC		~					1	TES 2 NO
IAN	DID TOBACCO U 25. WAS CASE REFERRED TO		RIBUIE TO CAL		E OF DEATH			NCERIAIN	۷Ц				
Sic	EXAMINER?		HOSPITAL: 1   Inpetient 2	ER/Outpatient 3	DOA 4	THER:	Home 5	Mesidence	6 🗆 Othe	r (Specify)			
BY PHYSICIAN:		Pending Investigation	28e. DATE OF II (Month, Day	NJURY /, Year)	26b. TIME O	'	WORK?	AT 2 NO	28d. DES	CRIBE HOW I	NJURY OC	CURED	
	3 Suicide 6	Could not be datermined	28e. PLACE OF building, e	INJURY — At horte. (Specify)	ma, farm, stree	it, lactory,	office			ATION (Street e or Town, State)	nd Number	or Rural Roo	ute Number,
COMPLETED			CIAN: To the best of a										ind menner as stated.
TO BE C	29b. SIGNATURE AND TITLE	ren (	Well	Rugi	1 Kda	0	29c.	LICENSE NUM	79 :	30	29d. DAT	E SIGNED (A	21, 1995
	MARVIN J	PEL	DMAN, M. I	. 301 5	ST. PAL	/	<u>,</u> #	407	BAL-	TO. M	D.	2120	a
	MARVIN J. FELDMAN, M.D. 301 ST. PAUL PL. #407 BALTO, M.D. 21202  31. DATE FILED (MONTH), Day, May)  JUN 2 2 1995  JUN 2 2 1995												



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	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR ERTIF	TMENT	OF H	EALTH DEA	AND I	MENT	L HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Last)								2. DAT	E OF DEATN	_		3. TIME OF DEATN	_
- 2	William	Adam	Maye	ski					Jui	Te 19	19	9 9 5	1:15p	) <sub>u</sub>
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lesi		IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DAT	OF BIRTN			PLACE (State or Foreign	
	215-24-1788	1 № M 2 🗆 F	67	YRS.	MONTHS	DAYS	HOURS	MIN.	T12	y 10	27	Count	ryland	
	9a. FACILITY NAME (If not institution, give st	met and number)			Oh CITY	TOWN O	D LOCATI	ION OF DE		<u>y</u> 10				_
DIRECTOR	Johns Hopkins		N.				imo		LAIN		9c. COU	NTY OF D		
2	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	B LOCAT	HON						10d. INSIDE CITY	Ξ
1 1 1	Maryland	NA			lti								LIMITS?	
	10e. STREET AND NUMBER												1 X YES 2 NO	
FUNERAL	North Bradford	Street	107				1224						States	
5	11. MARITAL STATUS		T EVER IN U.S. ARI		13. V	MAS DEC	ENDENT (	OF NISPAN	VIC ORIG	N? (Specify Yes	or No-	14. RACE	- American Indian, White, atc.	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 N	Ю	1	Yes, spe	2 NO	sn, Mexica Specify		Rican, atc.)			White	
	15. DECEDENT'S EDUC	ATION											77777 CC	
COMPLETED	(Specify only highest grade	completed)	(GF	ve kind of	USUAL OC work done of se retired.)	cupatio	on st of worki	ng	16	b. KIND OF BUS	SINESS/INE	DUSTRY		
Ž.	Elementary/Secondary (0-12)	College (1-4 or 5 -	-1		rer					Realt	or c	'omn	anu	
M		IVA		Парс	TEL					Realt	OI (	-Omp	any	
8	17. FATNER'S NAME (First, Middle, Last)	Ma	···oalri				16. MOT	HER'S NA	ME (First,	Middle, Malden			-1-4	
H	Alexander	Mo	yeski									zew	SKI	
10	19a. INFORMANT'S NAME (Type/Print)	4	196	MAILING	ADDRESS	(Street a	nd Number	r or Rural I	Route Nur	nber, City or Town	n, State, Zip	Code)	21224	Т
-	Grace Mayesk							St.	10	7 Bal	to.,	Ma	. 21224	
20e METHOD OF DISPOSITION 1 Comment of the Burlet 2 Cremetton 3   Department of the Burlet 2   Cremetton 3   Department of the Burlet 2   Cremetton 3   Department of the Burlet 2   Departmen														
	4 Donation 5 Other (Specify)		Sacre	d He	eart	of	Jes	sus	Jun	e 23	Dunc	lalk	, Md.	
1 1	21. SIGNATURE OF FUNEBAL SERVICEJLICE	MSEE /	1)	//	¥22. I	Da I	DADDRE	SS OF FA	7Ch	ojnac	ki F	. н.	P.A.	
	· Mark	111	Lucio	K	h o	05 1	Dund	lalk	Δτ	e. Ba	1to	M	d. 21224	
$\neg$	23. PART I. Enter the diseases, or o	emplications the	caused the de	eth. Do r	not enter	the mod	de of dy	Ing. suc	h an ce	diac or mani	retory er	7 11	Approximate	_
	agock, or heart failure. L	list only one can	on each line.		A								Interval Batwe	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Sociable Acute M/ E HARY THATA							Onset and Dat	ath					
	resulting in death)	10	OR AS A CONSEO			٠.			-	7,1	7 /	er .	2h	
		DOE 19	ASA CONSEC	UENCE U	r):					,			1/0	
RTIFICATION	Sequentially list conditions,	DUE TO	(OR AS A CONSEO	ALENOE O									Jan.	
F	If any, leading to immediate cause. Enter UNDERLYING	DOE TO	OR AS A CONSEU	- UENCE O	Ų.	11	)	from.						
일	CAUSE (Disease or Injury	Due m	OR AS A CONSEO	ne e	-	1	no	ten	for '				11-2 11,	
Ē	that initiated events reaulting in death) LAST	DOE 10	(OH AS A CONSEC	UENCE UI	-):	V								
18	d													
~	PART II. Other significant conditions	contributing to	death but not re	sulting	In the un	derlylna	cause	alven in	Part i.	24a. WAS AN	ALITOPSY	24b.	WERE AUTOPSY FINDING	ng.
MEDICAL				_						PERFOR			AMILABLE PRIOR TO COMPLETION OF CAUSE	
										1 🗌 YES 2	₽ NO		OF DEATH?	
Ξ	DID TODA CCO LICE CONTR	101177 70 01			- 5								1 TES 2 NO	
Z	DID TOBACCO USE CONTR	IBUTE TO CA					UNC	ERTAIN	1 10					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACI	E OF OEA	OTHER									
1 X	1 YES 2 NO	1 Inpatient 2	ER/Outpatient 3	□ DOA			5 🗆 Re	esidence	6 🗆 Oth	er (Specify)				
표	27. MANNER OF DEATN	28a. DATE OF (Month, D		28b. TIM	E OF URY	28c. INJU			28d. DE	SCRIBE HOW I	NJURY OC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation			1.00	М		ES 2 [	NO						
ED	3 Suicide 6 Could not be	28a. PLACE O	F INJURY — At horate. (Specify)	ne, ferm, c	street, facto	ry, office			281. LO	CATION (Street a	nd Number	or Rural A	oute Number,	
	4 Homicide determined								UII)	or rown, State)				
"	29a. CERTIFIER Check only	IAN: To the best of	my knowledge des	th occur-	of at the st	me dete	and place	and due	to the co	usalal and min	nas a			-
COMPLET													and manner as stated.	
8										proce, en	ade to In		and member as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		7				29c. LICE	ENSE NUM	BER		29d. DAT	ESIGNED	(Month, Day, Year)	
10			4				DI	140	21		J	ine	20, 1995	5
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM	273 (Tuno	Deint									



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

31. DATE FILED (MUN 202

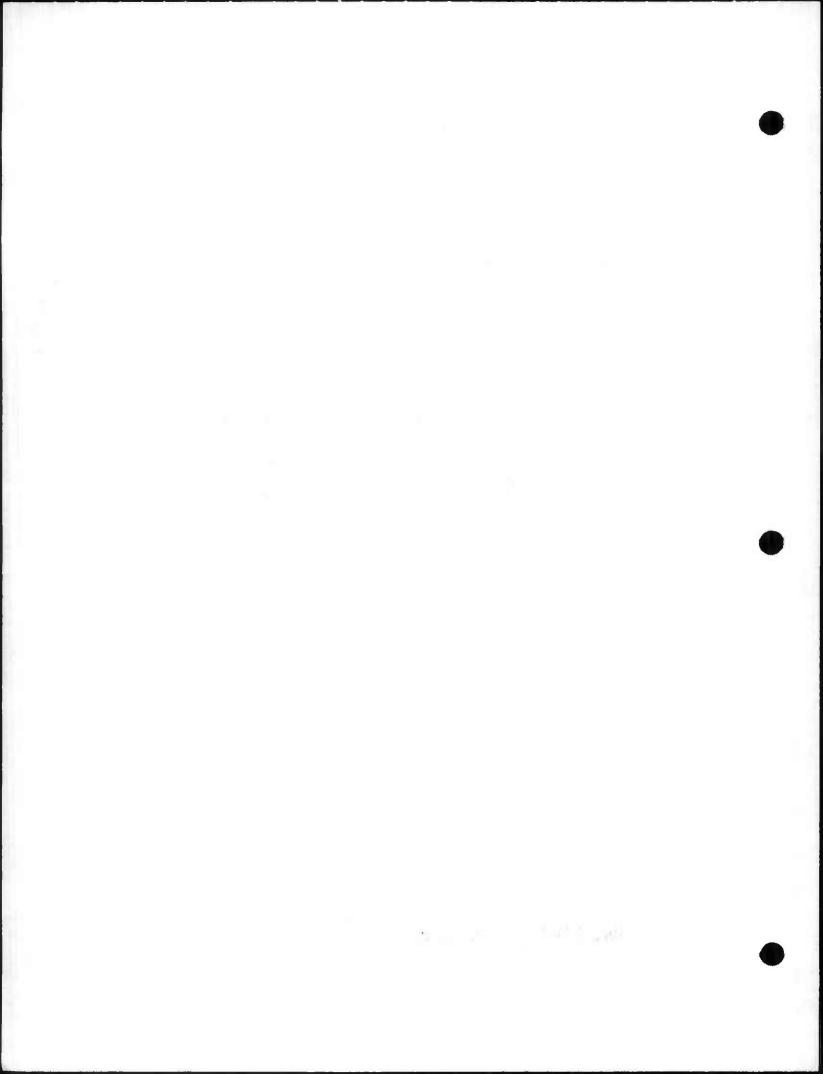
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32. REGISTRANS SIGNATURE

Eastern Blvd. Essex,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detected for use as the burial-transit nermit. Pages 1 2 3
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If I em 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 18839 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)
PATRICIA A 2. DATE OF DEATH 3. TIME OF DEATH MCNULTY JUNE 21. A.M 1995 08:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, B. BIRTHPLACE (State or Foreign 57 DAYS HOURS 1 M 2 X F YRS MIN. 213-36-0376 JUL 19 1937 MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CATONSVILLE 1 TES 2XXNO 10a. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 222 NEWBURG AVENUE 21228 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 K NO Specify: BY Specify: WHITE 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) REGISTERED NURSE 3 HEALTH CARE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN J. DRESSLER BE MARGARET NEUMAN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JOHN J. McNULTY 222 NEWBURG AVENUE, CATONSVILLE, MD 21228 20a. METHOD OF DISPOSITION
1 Aburlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Steta DATE MARY'S COLLEGE CEMETERY06-24 EMMITTSBURG, MARYLAND 4 Donation 6 Other (Specify) H. SIGNATURE GE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Phillips. STERLING ASHTON FUNERAL HOME, INC. Stails 736 EDMONDSON AVE., BALTIMORE, MD 21228 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Final** disease or condition **Onset and Death** due to Metastatia Non Smill cell DUE TO (OR AS A CONSEQUENCE OF): taclone ankaon resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER 1 | Inpatient 2 | ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO BY Investigation Accident 3 Suicide 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the heals of examination and/or (mentions in the first of the cause) and menner as stated. etion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

BE 10 30, NAME AND ADDRESS OF PERSON Hench

29c. LICENSE NUMBER 40229

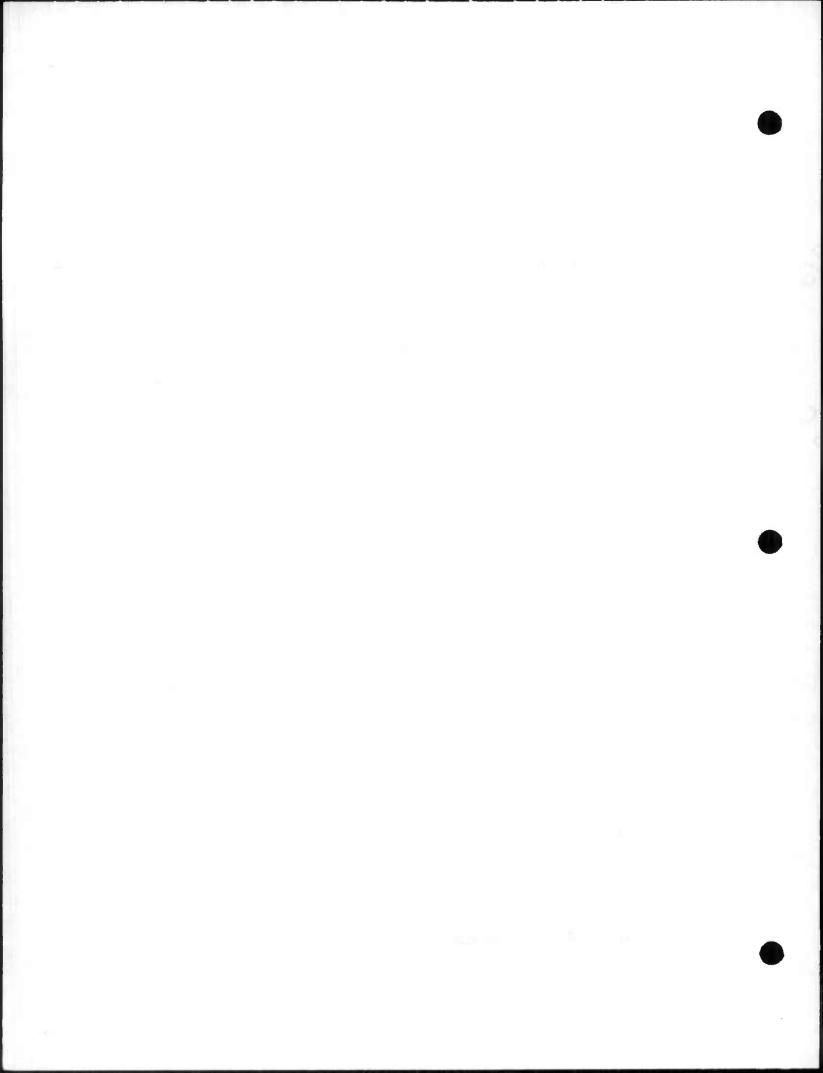
Beltime

29d. DATE SIGNED (Month, Day, Year) Dune 21, 1995

21229

DEATH (ITEM 27) (Type, Print) AYR

31. DATE FILED (Month, Day, Year)
JUN 2-2 1995



BALTIMORE, MARYLAND 21215-0020 as death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be assumer must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER  2.1.2-52-057  9a. FACILITY NAME (If not institution, give state)  RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  10c. STREET AND NUMBER  10b. COUNTY  11. Marital Status  12 Merried  15. DECEDENT'S EDUC (Specify only highest grade of the county of the county)  17. FATHER'S NAME (First, Middle, Last)  19a. INFORMANT'S NAME (Type/Print)  19b. INFORMANT'S NAME (Type/Print)  10b. METHOD OF DISPOSITION  11 Burisi 2 Cremetion 3 Ramo  1 Donaton 5 Dother (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIGHT  21. SIGNATURE OF FUNERAL SERVICE LIGHT	SHOPE STATE OF STATE
BALTIN BOX, P.O. BOX 68760 BALTIN at the death certificate be executed within 24 hours after death. Pag t by the attending physician and completely filled in by the funeral dis and Memal Hygiene prior to burial, cremation, or remoral. by Injury, or other traumatic event, the medical examiner	NOI	23. PART / Enter the diseases, or conshock, or heart failure. Limmediates or condition resulting in death)	omplications list only one
AECO requires to sen signed of Health	N: MEDICAL CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent conditions  DID TOBACCO USE CONTR	Dui
CLAN: The ertificate higher State Cor Item	PHYSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending	HOSPITAL 1 Inpatient 28a. DATI
VISION OF ATTENDING PHYSI RECTOR: After this of arts after death with The standard of the stan	BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLA bulk
DIV HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours TANT: If item	COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINER	
		290,6/GNATURE AND TITLE OF CENTIFIER	10

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT OF		MENTAL	HYGIENI REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	F DEATH		3. TIME OF DEATH
	BELDA D	1/2thia 1	MANGE		MONTH	DA	4	EAR CO. ST. TO
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. Is	est birthday) IF UNDER 1 YEA	D SE LIMBER 14 UPG	7. DATE OF			
	213-52-0571	10 M 2XF 47	YRS. MONTHS DAY		Month, I	Day, Year)	947 [	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give stre	eet and number)	96. CITY, TOW	N OR LOCATION OF D	EATH		9c. COUNTY	
בסוסשר	700 E. 21 ST	Street	Ba	Himor	37		N	A
ו	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LO	CATION				10d. INSIDE CITY
ב	Marylono	NA	Balt					LIMITS?
	100. STREET AND NUMBER	2.1		10f. ZIP CODE			10g. CITIZEN	OF WHAT COUNTRY?
	100 2.00	Street		2121	8		U.	513
5		12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2		ECENDENT OF HISPA			or No- 14.	RACE — American Indian, Black, White, etc.
-	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		specify Cuben, Mexic ES 2 NO Speci		an, etc.)		Specify: D
٩	3 Widowed 4 Diverced			1				Plack
	15. DECEDENT'S EDUCA (Specify only highest grade of		ECEDENT'S USUAL OCCUP	TION	16b. K	IND OF BUSI	NESS/INDUS	TRY
	Elementary/Secondary (0-12)		Give kind of work done during b. Do NOT use retired.)	most of working	na	2 ~1	. D	01
	12th anade	CO	ACE ASSIS	stant III	1		THO N	Ehanilation
5	17. FATHER'S NAME (First, Middle, Last)		100 11321	18. MOTHER'S N	-	201	CE	
5	Thomastan	Winht To		IN A V . T	AME (FIRST, MIO	idle, Maiden S		
7	THOY HIGH C	DEIGHT, ST.		IVVII	01 5 0	IN	JON.E	
	19s. INFORMANT'S NAME (Type/Print)	11	96. MAILING ADDRESS (Stre	et and Number or Rural	Route Number,	City or Town	State, Zip Con	10) 21215
1	3200/11 M 30F		509 WO	ODUAN	0 Hu	E CIP	1143	altimore mal
-1	100 METHOD OF DISPOSITION 100 Burisl 2 Cremation 3 Ramov		AND DATE OF DISPOSITION	Nama of	DATE!	20c. LOC	ATION — City	or Town, Stata
	Donation 5 ) Other (Specify)	cemetery, cr	rematory or other place)	Men Ca	0/19/9	1	monil	in marilano
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	A MAN O ILLO	AND ADDRESS OF F	VCILITY 2	(/^	Perc	TOKTOLLAR
	Le W				100	40	13	(2/2/00/2/2/
	Drughta	ne	ICH	ATMAL	- HAT	MSF.	W. B	altinure Man
	23. PART J. Enter the diseeses, or co	mplications thet caused the d	eeth. Do not enler the	node of dying, suc	h ss cardis	c or respin	story srrest	Approximate
	iMMEDIATE CAUSE (Finsi	st only one ceuse on each lin-	e.					Interval Between Onset and Death
	disesse or condition	Dahreden to						Onset and Death
	resulting in death) a.	Der Tolog as a course	$\sim$					a days
ı		G . /	EQUENCE OF):					
	Sequentially list conditions, b.	comagn	uo					6 mo.
	if any, leading to immediate	DUE TO (OR AS A CONSE	EOUENCE OF):					11
	CAUSE (Disease or injury	H1132						7 years
	that initiated events	DUE TO (OR AS A CONSE	EOUENCE OF):					
	resulting in death) LAST							
	PART II Other significant assessment	and the state of t						
	PART ii. Other significent conditions	contributing to death but not	resulting in the underly	ing ceuse given in	Part i. 24	4a. WAS AN A PERFORM		24b. WERE AUTOPBY FINDINGS AMAILABLE PRIOR TO
					1	YES 2		COMPLETION OF CAUSE OF DEATH?
						_ '		1 YES 2 NO
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	ATH YES INO	UNCERTAI	N D		i	
	25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Check only or					
		HOSPITAL:	OTHER:	_/				
	27. MANNER OF DEATH	I Inpatient 2 ER/Outpatient	T = True string Tr	ome 5 A Residence				
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	INJURY	NJURY AT VORK?	28d. DESCR	NBE HOW IN	JURY OCCUR	ED
	2 Accident Investigation		M 1	YES 2 NO				
	3 Suictde 8 Could not be	28e. PLACE OF INJURY — At he building, atc. (Specify)	oma, farm, street, factory, of	fica	28f. LOCATI	ON (Street an	d Number or F	Burel Route Number,
	4 Homicide determined				July of	July Siere)		
	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the heat of our bounds do	anth annumed at the state of					
		AN: To the best of my knowledge, do						
		On the basis of axamination and/or	investigation, in my opinion	, death occured at the	time, data an	d place, end	dua to the ca	use(s) and manner as stated.
	296 SIGNATURE AND TITLE OF CENTIFYER	1. 11.		29c. LICENSE NUI	MBER	T	29d. DATE SA	GNED (Minth, Day, Year)
	Dana do Sir	mels, MI)		D251	70		► 6/1	16/95
	30. NAME AND ADDRESS OF PERSON WHO	MPLETED CAUSE OF DEATH (ITE	EM 27) (Type, Print)	19321			-11	4/12
	808-810 5.	CONKIING	- ST 7	A150	MI	1 2	123	W
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	91 /3	TCIO	1-17	) 0	.00	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 6 mi
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			MAKTLANU /	/ DEPART	MENT OF	HEAITH AND	MENTAL HYGIEN	E		
1	1 - STATE REGISTRAR					F DEATH	REG. NO			
	1. DECEDENT'S NAME (Prol. Middle	N.	New	M9.	$\sim$		2. DATE OF DEATH MONTH D	% 198A	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 218-16-3490	1 □ M 2 🏻 F	5. SEX  6. AGE (In yrs. lest birthdey) IF UNDER  71 YRS. MONTHS			HOURA MIN.	7. DATE OF BIRTH (Month, Day, Year) April 2,	1924 MI	RTHPLACE (State or Foreign untry)	
OB	90. FACILITY NAME (If not institution Northwest Hos	spital Cente	r			n on Location of D lallstown	EATH	9c COUNTY OF	more Co.	
띦	RESIDENCE OF DECEDE  10e. STATE 10b. (	COUNTY		10c, CITY.	TOWN OR LO	CATION			10d. INSIDE CITY	
L DIRECTOR	MD 10e, STREET AND NUMBER	0.	Owi	ngs M	ills		1 YES 2 1			
ERA.	210 Emb1e	eton Road			- 1	21117		USA	F WHAT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 X Merrie 3 Widowed 4 Divorced	T EVER IN U.S. AI YES 2 A	RMED NO	If yes,		NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy:	14. R/B	ACE — American Indian, lack, White, etc.		
LETED	(Specify only higher Elementary/Secondary (0-12)	T'S EDUCATION est grade completed)  College (1-4 or 5 +	·) (C	e. Do NOT use i	rk done during retired.)	NTION most of working	16b. KIND OF BUS			
COMPL	12 17. FATHER'S NAME (First, Middle, L	Last)	НО	usewif	е	18. MOTHER'S N	domest			
BE C	Claude Twigg					196-31111-1911	Emma M. Che	esshire		
10	190. INFORMANT'S NAME (Type/Prin Joseph Newmar	,	19				Aoute Number, City or Tow Owings Mil			
	20e. METHOD OF DISPOSITION 1 Burlet 2 Comments 3 (		20b. PLACE cemetery, cre	AND DATE OF	DISPOSITION	(Name of	DATE 20c. LO	CATION — City or	Town, State	
22. NAME AND ADDRESS OF FACILITY  11824 Reis  Eline Funeral Home Reistersto  23. PART L Enter the plasman, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest  15. To the plasman of complication of the plasman of complication of the plasman of the								24 Reist	erstown Rd	
								eu e	Approximate interval Batw Onset and De	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	\ a (	OR AS A CONSE	ette	Abs-	se .				
MEDICAL (	PART II. Other significant cor	Sec xx	death but not	resulting in 5 Di Li	the underly	Caller	Pert I. 24a. WAS AN PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE C	ONTRIBUTE TO CA	USE OF DEA	TH YES	□ NO	UNCERTAI	NO			
DID TOBACCO USE CONTRIBUTE TO GAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO GAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO GAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO GAUSE OF DEATH YES NO NOTES AND ALL SAMINER?										
PH	27. MANNER OF DEATH	26e. DATE OF (Month, De	INJURY	28b. TIME C	OF 26c.	NJURY AT	28d. DESCRIBE HOW II	NJURY OCCURED		
B	1 Netural 6 Pendin 2 Accident Investig 3 Suicide 8 Could	Igation 25e PLACE OF	(Month, Day, Year) INJURY WORK?  M 1 YES 2 NO					264 LOCATION (Construct Number of Construction Number of Constructio		
	4 Homicide determine	building,	26e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, stc. (Specify)  26f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)							
ETED	29a. CERTIFIER	to the cause(e) end men								
ш	(Check only	XAMINER: On the beele of ex	emination end/or		my opinion				e(e) and manner on stated	
	(Check only 2 MEDICAL E)  29b. BIGNATURE AND TITLE OF CE	ERTIFIER	MS			29c. LICENSE NU	MBER 7034	20d. DATE SIGN	ED (Month, Day, Year)	
BE COMPLETE	(Check only one) 2 MEDICAL EX	ERTIFIER	MS	<b>M 27)</b> (Type, Pr	int)	T	7034	29d. DATE SIGN		

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTE	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bu
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KENDALL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JUNE 1:01 **JEANNE** NELSON 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, leat birthday) 7. DATE OF BIRTH (Month, Day, Year) SEPT. 24,1920 IF UNDER 1 YEAR IF UNDER 24 HRS BIRTHPLACE (State or Foreign 1 🗆 M 2 🖳 MONTHS DAYS. HOURS 212-18-8579 74 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR STELLA MARIS HOSPICE TOWSON BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE BALTIMORE 1 YES 2 XNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9 TENTMILL LANE, APT. B 21208 USA 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Ricen, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВУ Specify: 3 Wildowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) HOUSEWIFE OWN HOME 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) To MAX ZINSER 8 **ESTHER** RIBERKOF notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 MAXINE DUBINSKY 1209 KINGSBURY ROAD OWINGS MILLS, MD 21117 9 20a. METNOD OF DISPOSITION 1 X Burlel 2 Cremation 5 Removal from State
4 Donation 5 Oth (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must HAR SINAI 6-20-1995 OWINGS MILLS, MD examiner 21. SIGNATURE OF BAL SERVICE LICENSE SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 medical 26 PART I. Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** 3 disease or condition BREAST CANCER event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY any 1 TES 2 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5 ☐ Residence 6 📉 Other (Specify) 0 Hospice 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 26d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 2 Accident 5 Pending Investigation м 1 YES 2 NO BY 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 6 Could not be 4 Homicide 28 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MPORTANT: H 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 125642 Praall 10

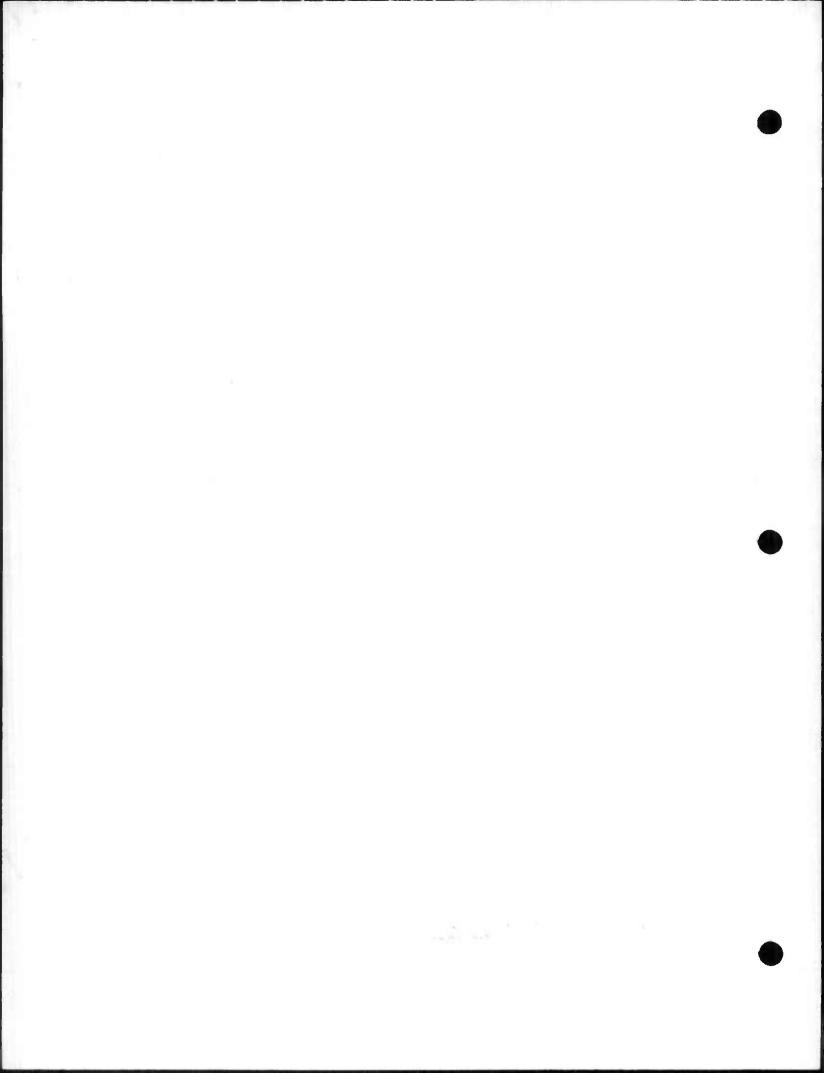
bulling

2300 DULANEY VALLEY RD., TOWSON, MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32. The STI APE STATUTE

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Pages 1, 2, 3 should

permit.

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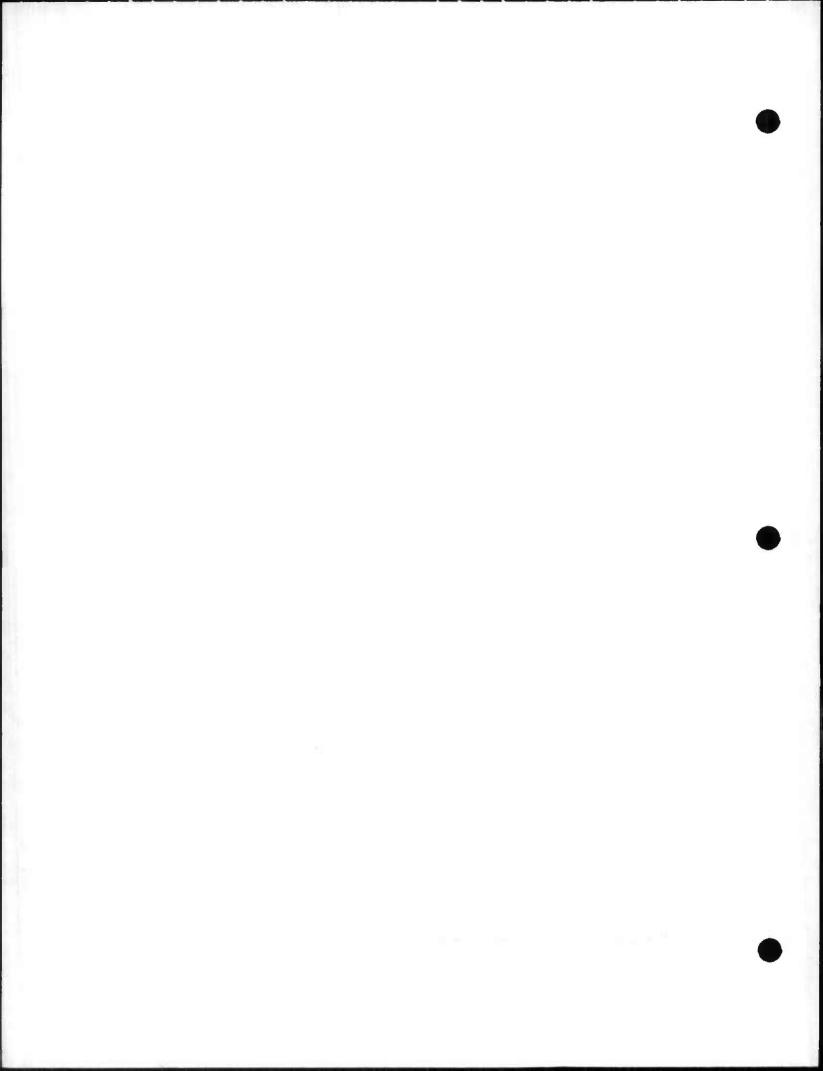
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the hospital or attending physician.	e detached for use as the burial-trans	rt once.
within 24 hours after death. Page 6 may be retained	pletely filled in by the funeral director, page 5 should cremation, or removal.	rent, the medical examiner must be notified
law requires that the death certificate be executed w	as been signed by the attending physician and comp Dept. of Health and Mental Hydlene prior to burial. c	23 shows any Injury, or other traumatic eve
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Dept. of Health and Mental Hydlene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 0910Am Ann arrar JUne A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign SEPT. 21, 1936 233-52-2968 58 1 M 2 X YRS. 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN DR LOCATION OF DEATH Sc. COUNTY OF DEATH UNIVERSITY DIRECTOR HOSPITAL BALTIMORE C ITY n/a RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 VES 2 NO MARYLAND BALTIMORE n/a 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1219 POTOMAC STREET STATES N. 21213 UNITED 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO RACE — American Indian, Black, White, etc. FDRCES? 1 YES 2 1 Never Married 2 Married
3 Widowed 4 Divorced BY Specify: BLACK ETED. 15. DECEDENT'S EDUCATION 15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) COMPL 10 th HOUSEWIFE DOMESTIC 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname PAUL BIGELOW GLADYS FARLEY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1219 N. POTOMAC STREET, BALTIMORE, MD 21213 2 PARRAN **JACQUELINE** 20a. METHOD OF DISPOSITION
1 XX Purial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State BALTIMORE Place EM. 26 BALTIMORE, MD 4 Donation 5 Other (Specify) 6-21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVE. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) 2 days DUE TO (OR AS A CONSEQUENCE OF) Uncontrolled CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OEȘCRIBE HOW INJURY OCCURED 1. Natural 5 Pending BY 1 YES 2 NO Investigation 2 Accident 28e. PLACE DF INJURY — At home, larm, streel, lectory, office building, etc. (Specify) ETED ! 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. COMPL 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 21

MOK MD Hosp. 225. Greene avid

COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)



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<b>BALTIMORE, MARYLAND 21215-0020</b>	he hospita	detached f
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DIVISION OF VITAL

DALLIMORE, MARTLANI	cuted with	d completely filled in by the funeral director, page 5 should be detache urial, cremation, or removal.	ic event, the medical examiner must be notified at once.
DIVISION OF VILAE RECORDS, P.O. BOA 607 00.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Vivek C. Vaid, M.D.,

31. DATE FILED (Month. Day, 1995)

JUN 2 2 1995

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		RTMENT								
	1. DECEDENT'S NAME (First, Middle, Last)		EHIIF	ICATE	UF	DEAI	н		EG. NO			
		(IID ANDE						2. DATE OF I	D/		YEAR	3. TIME OF DEATH
	JULIUS PON	5. SEX 6. AGE (In yrs.			]			June		1995		6:05 PM M
		MX M 2 F	YRS.	IF UNDER 1	DAYS	HOURS :	MIN,	7. DATE OF E (Month, De	y, Year)		8. BIRT	HPLACE (State or Foreign try)
	056-07-2423A	86	THS.						16.	1908		ıssia
~	9e. FACILITY NAME (If not institution, give str		9b. CITY, T	TOWN OI	R LOCATIO	N OF DE	EATH		9c. COU	INTY OF I	DEATH	
0	1836 Metzerott Ro	oad		A	del	phi				Pri	nce	Georges
DIRECTOR	10a. STATE 10b. COUNTY		10c CI	Y. TOWN OR	LOCATI	ON						10d. INSIDE CITY
E	Maryland Princ										LIMITS?	
	100. STREET AND NUMBER	ce Georges		delph	7	ZIP CODE						1XXYES 2 NO
FUNERAL		•			101.							WHAT COUNTRY?
뿐	1836 Metzerott Ro					2078					SA	
	1 Never Married 2 X Married	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2						NIC ORIGIN7 (S		or No-	14. RAC Blac	E — American Indian, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	IF YES, GIVE WAR OR DATES 1 TYPE			2 NO	Specify	y:			Specify:	
	15. DECEDENT'S EDUC	ATION 160	DECEDENT	USUAL OCC	CHRATIO			405 1/10	D 05 N/			White
	(Specify only highest grade of	completed)		work done du			7	100. KIN	U OF BU	SINESS/INI	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)		ippin	o C	lerk		Ga	rmer	ıt In	duet	. 2.2.2
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			тррти	.6 0.		5010 111				.uus c	-1 y
	Hillel Pomerantz							ME (First, Middl Leah (U				
BE	19a. INFORMANT'S NAME (Type/Print)											
2	David Pomerantz							Route Number, C				
	20a. METHOD OF DISPOSITION						Ave	., Lau				d 20706
- 1	1 X Burlet 2 Cremetion 3 Remo	val from State 20b. PLAC	EAND DATE crematory or o	of dispositive place)	ION (Nan	ne of	/16	/1995	20c. LO	CATION —	City or T	own, State
_	4 Donation 5 Other (Specify)		Monte						Que	ens,	New	York
	Donald C.	^	yer	STE:	IN F	ADDRES HEBRE RROLL	W M	EMORIA	L FU	NERA	L HO	ME, INC. DC 20012
	23. PART I. Enter the diseases, or co	omplicatione that caused the	deeth. Do	not enter th	he mod	le of dyle	ıg, suc	h ea cardiac	or rasp	Iratory ar	rest,	Approximata
	IMMEDIATE CAUSE (Finel	let only one ceuse on each l	ne.									Interval Between Onset and Death
	disease or condition	Cerrolae	0.16	26	<del>1</del>							
	resulting in death) a											lomin
_	-	DUE TO (OR AS A CON!  DUE TO (OR AS A CON!  COM EN COV. C  DUE TO (OR AS A CON!	2/01/	·	6.10	10	10	nachla	110 h	1064	-Land	m. 15926
CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CONS	EOUENCE O	h:	144			7000	V C / C		10000	UIG 10 YS
8	cause. Enter UNDERLYING	Cos cinoma	81	own a	Ola	~	Ma	olonge	OLLI	1		2195
画	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONS	EOUENCE O	F):	CVL	6	110		- 000			
토	reaulting in death) LAST	Anomia	M	ulh	al	loch!	a()	cul	mel	MJ		5 95
2				0	3					(1		
A	PART II. Other aignificent conditions	A /	t reculting	in the unde	erlying	ceuse g	lven in	Part I. 24e	PERFOR	AUTOPSY	241	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
음	carunomo		1 1						YES 2			COMPLETION OF CAUSE OF DEATH?
¥	GINLY 150	ONTRIBUTE TO CAL	young s	iemo	1							1 YES 2 NO
ä	DID TOBACCO USE C	ONTRIBUTE TO CAL	ISE OF	DEATH	YE	S 🗌	NO	<b>2</b>				
¥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PL/	ACE OF DE	ATH (Ch	eck only one)				
PHYSICIAN: MEDICAL	1 VES 2 NO.	HOSPITAL: 1   Inpetient   2   ER/Outpetient	3 DOA	OTHER:	ng Home	5 KRee	idenca	6 Other (Sp	eclfv)			
Ť	27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIA	E OF 2	Bc. INJU	RY AT		28d. DESCRI		NJURY OC	CURED	
	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	- IN-	JURY M	WOF	RK? ES 2 🗌	NO					
BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY — At	home, farm,	street, factor	y, office			28f. LOCATIO	N (Street I	and Numbe	r or Rumi	Route Number,
Ĭ	4 Homicide determined	building, atc. (Specify)						City or To	wn, Stele)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	TAN: To the heat of an inch to	district a second						300	MO FOUR	Dist.	
MP		NAM: To the best of my knowledge, R: On the basis of axamination and/										Mark a Francisco
8			·····veacigatii	on, or my opt	mott, de				prace, an	ou due to fi	ne cause(	ej end menner as stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LICEI				29d. DAT	E SIGNE	D (Month, Day, Year)
2							115	195				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (For Original											

of Person who completed cause of Death (ITEM 27) (Typo, Print)
aid, M.D., 3311 Toledo Terrace, Suite 102B, Hyattsville, MD 20782

DHMH-16 Rev 1/89

The problem and the

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-Es hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 be flied within 72 hours after death with the State Destr of Health and Mental Hotiere prior to burial, cremation or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
IYSICIAN: The law requires that the death ce	is certificate has been signed by the attendir ith the State Dect. of Health and Mental Hw	ed, or Item 23 shows any Injury, or
TO THE HOSPITAL OR ATTENDING PH	TO THE FUNERAL DIRECTOR: After the be filed within 72 hours after death w	IMPORTANT: If item 28 is mark

	1 - STATE REGISTRAR				) / DEPAI CERTIF					MENTAL HYGIEN REG. NO			
	1. OECEDENT'B NAME (First, Barry	Middle, Last)	Stanley	Pus	hkir	1				2. DATE OF DEATH DATE THOUSE	8 /	YEAR 995	3. TIME OF DEATH 0140 M
	4. SOCIAL SECURITY NUMBER 214 38 16		5. SEX 1 M 2 F		53 yrs.	IF UNDER	DAYS	IF UNDER 2	MIN.	7. DATE OF BIRTH 1942 8. BIRTHPLACE (State or Forei (Month, Dey, Year) 1942 MARYIJAND			
~	9a. FACILITY NAME (If not ins							OR LOCATIO		ATH	9c. COU	NTY OF DE	
DIRECTOR	NORTHWEST I		AL CENTE	R			RAND	ALLSI	LOWN			BALT	IMORE
EC.	10a. STATE	10b. COUNTY			10c. Cl	TY, TOWN C	OR LOCAT	TION				T	10d. INSIDE CITY
	MARYLAND			N/A			BALI	IMORE	3				LIMITS?
₹	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	ZEN OF WI	NAT COUNTRY?	
FUNERAL	1814 GREENE	BERRY I						2120				US	
	11. MARITAL STATUS 1 Never Married 2 1	Warrlad	12. WAS DECEOEN FORCES? 1	YES 2	<b>™</b> NO		It yes, sp	ecify Cuban,	, Mexican	IC ORIGIN? (Specify Year, Puerto Rican, atc.)	or No	14. RACE Black,	- American Indian, White, stc.
B	3 Widowed 4 Divon	ced	IF YES, GIVE V	MAR OR DATES			1 TYES	X□ NO	Specify			Spec/fy	WHITE
E		DENT'S EDUC		16a	DECEDENT'S	USUAL OF	CCUPATIO	ON sel of weeking		16b. KIND OF BU	SINESS/INC	USTRY	
9	Elementary/Secondary (0-		College (1-4 or 5	+)	life. Do NOT u	se retired.)	ouring mo	ST OF WORKING	,				
COMPLET	17. FATHER'S NAME (First, Mic	(#: 1 - A)			SELF	EMP	LOYE			CABINE		KER	
BE CO	IRVIN		PU	SHKIN				S	SOPH				NKNOWN
5	MS. WENDI		N		19b. MAILING 1814	GREE	(Street a	RY RC	or Rural A	oute Number, City or Tow BALTIMORE	n, State, Zip MD	21209	
	20a. METHOD OF DISPOSITIO	N 3 Pamo	and from State		CE AND DATE		ITION (Na	me of		DATE 20c. LO	CATION -	City or Tow	n, State
	4 Donation 8 Other (	Specify)		Cametary,	Crematory or C	YOUN	G ME	NS -	6-1	9-1995 BAI	TIMO	RE, M	ID
	21. SIGNATURE OF FUNERAL	SERVICE, LICE	MSEE	7,1	7			T EVETN		& BROS.,	TNIC		
	Sell	WV	M. Lu	de	6							TMOE	E, MD 21215
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abook, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. Metastate gastre aderocarchome 2 yrs  DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	if any, leading to immad cause. Enter UNDERLYIN CAUSE (Disease or injur that initiated events	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c											
-	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  Sepsis, Anemia, lymphatic pulmorary mets 1 yes 2 pl NO												
MEDICAL	Sepsis,	Α,	nemia,	14	mpha	tre	pul	monar	ven in F	PERFOR	RMED?		VERE AUTOPSY FINDINGS NAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO
AN: MEDICAL	DID TOBACCO US	A,	nemia,	USE OF D	mpha EATH YI	tru ES   I	pul	monar	-y M	PERFOR	RMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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HYSICIAN: MEDICAL	DID TOBACCO US	E CONTR	BUTE TO CA	USE OF D	EATH YI	ES NTH (Check of OTHER 4 Num	NO Donly one)	UNCE	RTAIN	PERFORM 1 YES 2	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Natural 5 P	E CONTR MEDICAL	BUTE TO CA	USE OF D  26. P  ER/Outpatient	EATH YILACE OF DEA	ES NTH (Check of OTHER 4 Num	NO Conly one) R: sling Hom- 28c. INJI WO	UNCE	RTAIN	PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Naturat 5 PA 2 Accident In	E CONTR MEDICAL  ending westigstion	IBUTE TO CA HOSPITAL: 1 Inpetient 2 (Month, D) 28e. PLACE O	USE OF D  26. P  ER/Outpatient INJURY ey, Year)	EATH YILACE OF DEA	ES NTH (Check of OTHER 4 Number of Jury M	NO Donly one) 3: sing Home 28c. INJI WO 1 U	UNCE  • 5   Rael  URY AT  RK?  YES 2	ERTAIN Idence !	PERFORM 1 YES 2	NJURY OCC	CURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! YES 2 NO
ED BY PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Natural 5 P  2 Accident  3 Suicide 8 C	E CONTR MEDICAL	IBUTE TO CA HOSPITAL: 1 Inpetient 2 (Month, D) 28e. PLACE O	USE OF D  26. P  ER/Outpatient INJURY ay, Year)	EATH YILACE OF DEA	ES NTH (Check of OTHER 4 Number of Jury M	NO Donly one) 3: sing Home 28c. INJI WO 1 U	UNCE  • 5   Rael  URY AT  RK?  YES 2	ERTAIN Idence !	PERFORM 1 YES 2  1 Other (Specify) 28d, DESCRIBE HOW I	NJURY OCC	CURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! YES 2 NO
ED BY PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Naturat 5 PA  2 Accident In  3 Suicide 8 C  4 Homicide de  29a. CERTIFIER (Check only)	E CONTR MEDICAL  ending vestigation ould not be elarmined	IBUTE TO CA HOSPITAL: 1 Inpetlent 2 28a. DATE OF (Month, D) 28a. PLACE Obuilding,	USE OF D  26. P  ER/Outpatient INJURY ey, Year)  F INJURY — At etc. (Specify)  my knowledge	EATH YI LACE OF DEA  28b. TIM IN.	ES INTH (Check of OTHER 4 INTH MINING	NO DONNY one) 3: sling Home 28c. INJ 1 V ory, office	UNCE  5 Rael  UF AT  RKY  (ES 2 and pleca, a	RTAIN  Idence I	PERFORM 1 YES 2  1 Other (Specify)  28d. DESCRIBE HOW 1  281. LOCATION (Street	NJURY OCC	CURED or Rural Ro	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  YES 2 NO
E COMPLETED BY PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Naturat 5 PA  2 Accident In  3 Suicide 8 C  4 Homicide de  29a. CERTIFIER (Check only)	E CONTR MEDICAL  ending westigstion ould not be elarmined  FYING PHYSIC AL EXAMINER  OF CERTIFIER	IBUTE TO CA HOSPITAL: 1 Inpetiant 2 28a. DATE OF (Month, D 28e. PLACE O building, IAN: To the best of a:	USE OF D  26. P  ER/Outpatient INJURY ey, Year)  F INJURY — At etc. (Specify)  my knowledge	EATH YI LACE OF DEA  28b. TIM IN.	ES INTH (Check of OTHER 4 INTH MINING	NO DONNY one) 3: sling Home 28c. INJ 1 V ory, office	UNCE  5 Gael  UNY AT  RK?  YES 2 Gael  and pleca, a  eath occured	NO NO NO NO NO NO NO NO NO NO NO NO NO N	PERFOR  1 YES 2  1 VES 2  1 VES 2  1 VES 2  2 VES 2  2 VES 2  3 Other (Specify)  2 VES 2  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 2  3 Other (Specify)  2 VES 3 Other (Specify)  3 Other (Specify)  2 VES 3 Other (Specify)  3 Other (Specify)  2 VES 4 Other (Specify)  2 VES 4 Other (Specify)  2 VES 5 Other (Specify)  2 VES 6 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  2 VES 7 Other (Specify)  3 VES 7 Other (Specify)  3 VES 7 Other (Specify)  3 VES 7 Other (Specify)  3 VES 7 Other (Specify)  4 VES 7 Other (Specify)  4 VES 7 Other (Specify)  4 VES 7 Other (Specify)  4 VES 7 Other (Specify)  5 VES 7 Other (Specify)  5 VES 7 Other (Specify)  5 VES 7 Other (Specify)  5 VES 7 Other (Specify)  6 VES 7 Other (Specify)  6 VES 7 Other (Specify)  6 VES 7 Other (Specify)  6 VES 7 Other (Specify)  7 VES 7 Other (Specify)  7 VES 7 Other (Specify)  7 VES 7 Other (Specify)  7 VES 7 Other (Specify)  7 VES 7 Other (Specify)  8 VES 7 Other (Specify)  9 VES 7 Other (Spec	NJURY OCC	or Rural Ro	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  YES 2 NO  JOURNEL NO NO NO NO NO NO NO NO NO NO NO NO NO
BE COMPLETED BY PHYSICIAN:	DID TOBACCO US  25. WAS CASE REFERRED TO EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Naturat 5 P 2 Accident In 3 Suicide 8 C 4 Homicide de  29a. CERTIFIER (Check only one) 2 MEDIC  29b. SIGNATURE AND TITLE C	DE CONTR MEDICAL  ending westigstion ould not be elarmined  FYING PHYSIC AL EXAMINER  OF CERTIFIER	IBUTE TO CA HOSPITAL: 1 Propellant 2 28a. DATE OF (Month, D 28e. PLACE O building.  IAN: To the best of a:	USE OF D  26. P  ER/Outpattern INJURY ey, Year)  F INJURY — Al etc. (Specify)  my knowledge camination and	EATH YILACE OF DEA	ES NTH (Check of OTHER 4 Number of N	NO DONNY one) 3: sling Home 28c. INJ 1 V ory, office	UNCE  5 Gael  UNY AT  RK?  YES 2 Gael  and pleca, a  eath occured	NO NO NO NO NO NO NO NO NO NO NO NO NO N	PERFOR  1 YES 2  1 VES 2  1 Other (Specify)  28d. DESCRIBE HOW I  City or Town, State)  o the cause(a) and mer  Ime, date and plece, an	NJURY OCC	or Rural Ro	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO  Jule Number,  and manner se stated.  Aonth, Day, Year)
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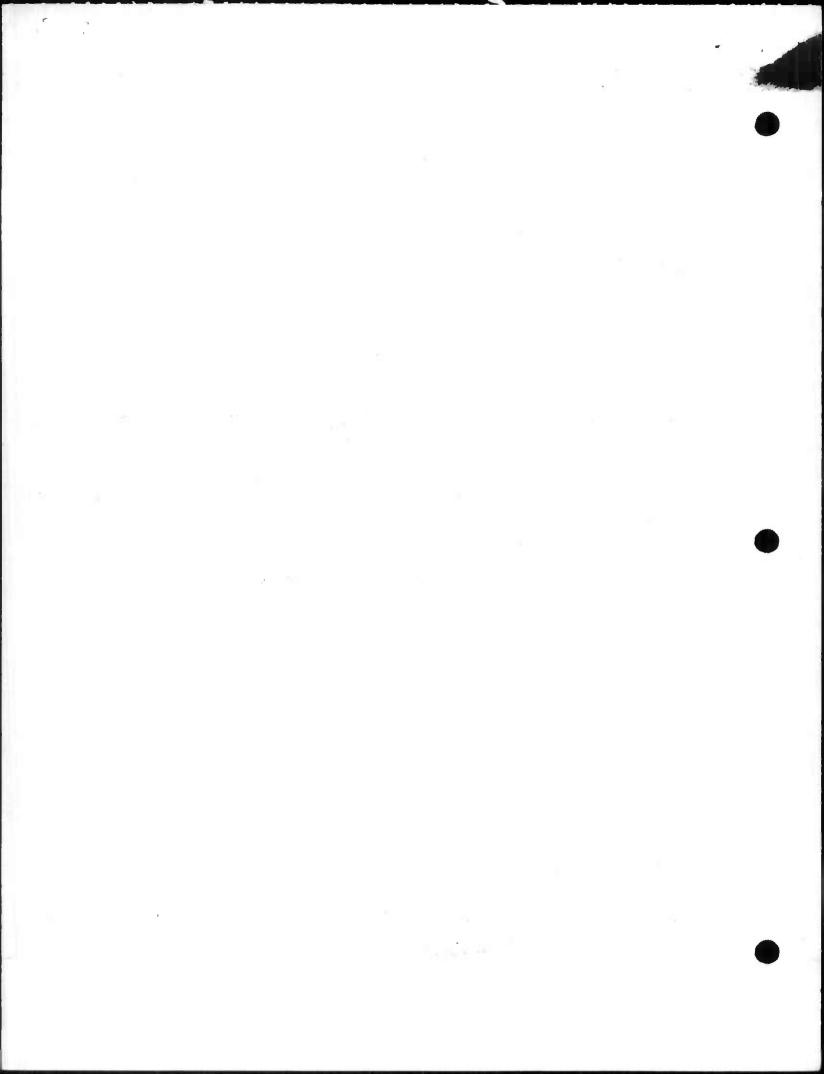
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an included the factor of the hospital or attending physician.

TO THE RUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND C		T OF HEALTH AND	MENTAL HYGI					
	1. DECEDENT'S NAME (First, Middle, Last)	12			2. DATE OF OEAT	. DAY	3. TIME OF DEATH			
	LAWYENCE  4. SOCIAL SECURITY NUMBER  5.	Price SEX 6. AGE (In yrs. In	est historia de la comp	ER 1 YEAR IF UNDER 24 HAS.	June 1	3 199	BIRTHPLACE (State or Foreign			
	218-76-5532 1	218-76-5532 1 MM 2 0 F 82 YRS. MONTHE DAYS HOURS MIN. 03-13-1913 Country)								
DIRECTOR	Nercy Medical Center  RESIDENCE OF DECEDENT  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH  NA  PACIFICATION OF DEATH  96. COUNTY OF DEATH  NA  PACIFICATION OF DEATH  NA  P									
JEC.	10g. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.									
	Maryland 100. STREET AND NUMBER	N/A	101. ZIP CODE		10g, CITIZE	LIMITS?  1 VES 2 NO  N OF WHAT COUNTRY?				
FUNERAL	11. MARITAL STATUS 12	AVE. WAS DECEDENT EVER IN U.S. A	11 Ave, 21201							
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 IN IF YES, GIVE WAR OR DATES	NO 1:	It was decendent of Hispa If yes, specify Cuben, Maxic 1 YES 2 NO Speci	an, Puerto Ricen, etc.	Yea or No- 14	I. RACE — American Indian, Black, White, etc.			
	15. DECEDENT'S EDUCATION		ECEDENT'S USUAL	OCCUPATION	16b, KIND OF	BUSINESS/INDUS	DIACK			
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)		B. Do NOT use retired	e during most of working		(I/A				
OMO	17, FATHER'S NAME (First, Middle, Last)	0	inen	ployed	/	V//1				
	Samuel W P	rice.		BOS (	AME (First, Middle, Ma	Pri	0			
TO BE	199. INFORMANT'S NAME (Type/Print)	1 1	b. MAILING ADDRE	SS (Street and Number or Rural	Route Number, City or	Town, State, Zip Co	ode)			
F	Alberta Hai	rdy lá		shburtor	St.	Batto.	Md. 21216			
	20a. METHOO OF DISPOSITION  1		AND DATE OF DISPO		6/16/15 7	20 1 - CIR	y or Town, State			
	PL SIGNATURE OF FUNERAL SERVICE LIVENS	SEE O		NAME AND ADDRESS OF F	1	<u> </u>	11/10/1			
	· Jajeph)	I. Ku	11	oseph TV	745 SI	ruber	Tal Hame			
	23. PARTY I / Enter the diseases, or com	pilications that coused the d	esth. Do not ente	or the mode of dying, suc	ch sa cardiac or ri	espiretory arrea	t, Approximata			
	iMMEDIATE CAUSE (Finei	11 1	- 1				Onset and Death			
	resulting in death) e	DUE TO (OR AS A CONSE	allure				years			
z		END Strice Remail Disease								
AT10	Sequentially list conditions, if sny, lasding to immediata csuse. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF):							
FIC.	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):							
CERTIFICATION	resulting in deeth) LAST									
AL C	PART ii. Other significant conditions c	ontributing to deeth but not	resulting in the t	underlying ceuse given in	Part i. 24a, WA	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
	atrial Fibril	lation			PER	FORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE			
MEC	Dementia					05	OF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB				N 🗆					
Sici	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1	OSPITAL:  Inpatient 2 ER/Outpatient :	CE OF DEATH (Chec	R:						
μŽ	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT	6 U Other (Specify)  26d. DESCRIBE HO	OW INJURY OCCUP	RED			
BY	1 Nstural 5 Pending 2 Accident Investigation	(MOTHI, Day, Teal)	INJURY M	WORK? 1 YES 2 NO						
COMPLETED	3 Suicida 8 Could not be determined	28s. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, street, fa	ctory, office	281. LOCATION (Str City or Town, S	eet and Number or tate)	Rural Route Number,			
PLE	29a. CERTIFIER t CERTIFYING PHYSICIAN	N: To the best of my knowledge, d	eath occurred at the	time, data and place, and due	to the cause(a) and	manner as atated.				
ŏ.		on the basis of examination and/or								
BE	296 SUMMATURE AND TITLE OF CERTIFIER	ama		29c. LICENSE NU	MBER	29d. DATE S	IGNED (Month, Day, Year)			
- 1	1 1 1 1 1			[ [ [ ] [ ] [ ] ] "	11	1 //				
	30 MANE AND ADDRESS OF BEDGON WAYS	OMPLETED CAUSE OF STATES	MAD (X- C)	1081.	16	offere	13,1995			
10	30. HAME AND ADDRESS OF PERSON WHO CO DWOVNE BO 31. DATE FILED (Month, Day, Year) JUN 2 2 1995  July	OMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	1 Place	Balto	Md.	21202			

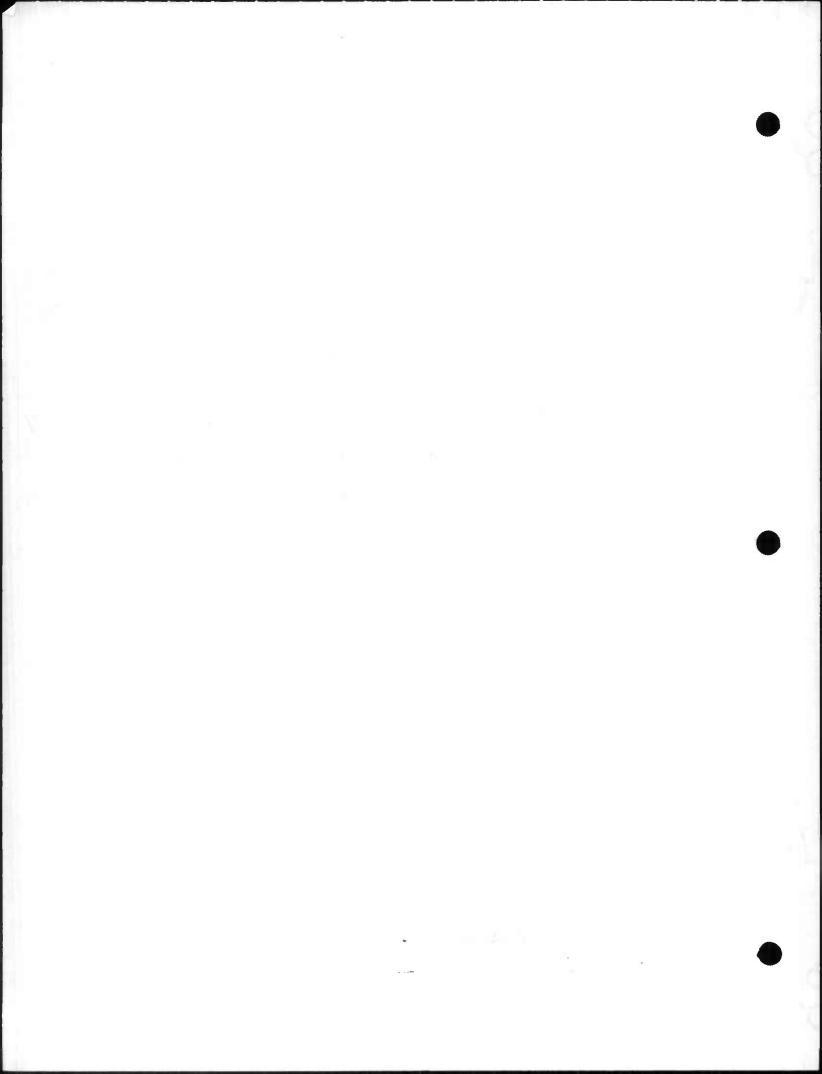


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		4 DECEMBER NAME (First Address Land		OLITTI I	OAIL OI	DEATH	HEG. NO.		
	1	1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY	PAR	RKER			2. DATE OF OEATH	99	2 TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 051-36-3984		AGE (In yrs. lest birthday)  53 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		ITHPLACE (State or Foreign
. 3 should	NG.	STELLO MAN	reet end number)		96. CITY, TOWN	DR LOCATION OF DE		9c. COUNTY OF	DEATH A
5,	5	RESIDENCE OF DECEDENT			2011				,
permit. Pages	DIRECTOR	Maryland 106. COUNTY	N/A	F	30 Hin	10re			10d. INSIDE CITY LIMITS? 1 YES 2 NO
ust.	FUNERAL	2205 Tucke	r Lan	e Apt B7	10	2120°	7	10g. CITIZEN OF	SA SA
ding physician. s the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1   IF YES, GIVE WAR	YES 2 PNO	If yes, sp		NC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	Bi	ACE — American Indian, ack, White, atc.
hospital or attending ached for use as the	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w	rork done during mo	on osl of working	16b. KIND OF BUS	SINESS/INDUSTRY	10mo
by the	6 111	17. FATHER'S NAME (First, Middle, Lest)	Dexto	r		18. MOTHER'S NA	ME (First, Middle, Maiden	Syrrama	101116
5 should	TO B	190. INFORMANT'S NAME (TYPORTION) GEORGE Park	ér	19b. MAILING 2205	ADDRESS (Street a	hand Number or Rural I	Poute Number, City or Town	n, Store Zip Code)	Nd. 21207
e 6 may rector, pa		20s_METHOD SP DISPOSITION 1 Marie 2 Cremetton 3 Remote 4 Donation 6 Other (Specify)	oval from State	20b. PLACE AND DATE O		Forest	DATE 20c. LOG	CATION — City or	Town, State Mills Md.
		21. SIGNATURE OF FUNERAL SERVICE OF	ENSEE /	Russ	Jose	NO ADDRESS OF FA	USS FU	neral	Home
by the emoval.		23. PART / Enter the diseases, or o	omplications that co	sused the deeth. Do n	ot enter the mo	de of dying, suci	aa cardiac or respi	ratory arrest.	Approximate
filled i		IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause	on sech line.					Interval Between Onset and Death
8 2 = 1		V	DUE TO (OF	AS A CONSEQUENCE OF	):				
n and to bur	ATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEQUENCE OF	):				
ending phy Il Hygiene	ERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEQUENCE OF	):				
the atten Mental H		PART II. Other algoliticant condition	contributing to de	ath but not reaulting is	n the underlying	g ceuse given in	Part I. 24a. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
sign es	EDICAL CI	BRAIN OLI	VER M	NETASTA	232		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: The law requirections of the State Dept. of H	Z	DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DEATH YE	S NO C	UNCERTAIN	N/C		1 PES 2 NO
N: The Licate has State De	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT					
CLAN: entifica	YSI	1 TYES 2 XNO	1  Inpatient 2  EF	3/Outpetlant 3 DOA		e 5 🗆 Rasidenca	6 X Other (Specify)	Hospice	2
After this c	ВУ РН	27. MANNER OF SEATH  1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJ (Month, Day,	(NJC	M 1 .	PRK? YES 2 NO	28d. DESCRIBE HOW IN		_
OR ATTENDING PHYS. DIRECTOR: After this hours after death with	ETED	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF IN building, atc.	IJURY — At home, farm, at (Specify)	treet, factory, offic		261. LOCATION (Street a City or Town, State)	nd Number or Run	/ Route Number,
世 コママ	립			knowledge, death occurred Institution and/or investigation					e(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE (	290. SIGNATURE AND TITLE OF CERTIFIER  ON OUR STATE OF PERSON WHO	Completed Cause	ellalu	NO Delet	29c. LICENSE NUM	943	29d. DATE SIGNI	ED (Month, Day, Year)
^		DR. KENDALL FAU		O DULANEY V		D TOUS	ON MD 2	1204	
8		JUN 2 2 1995	32 REGUTHAR'S	GNATURE	THE I	LOWD!	on, em 2.	1204	
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30. NAME AND ADDRESS OF

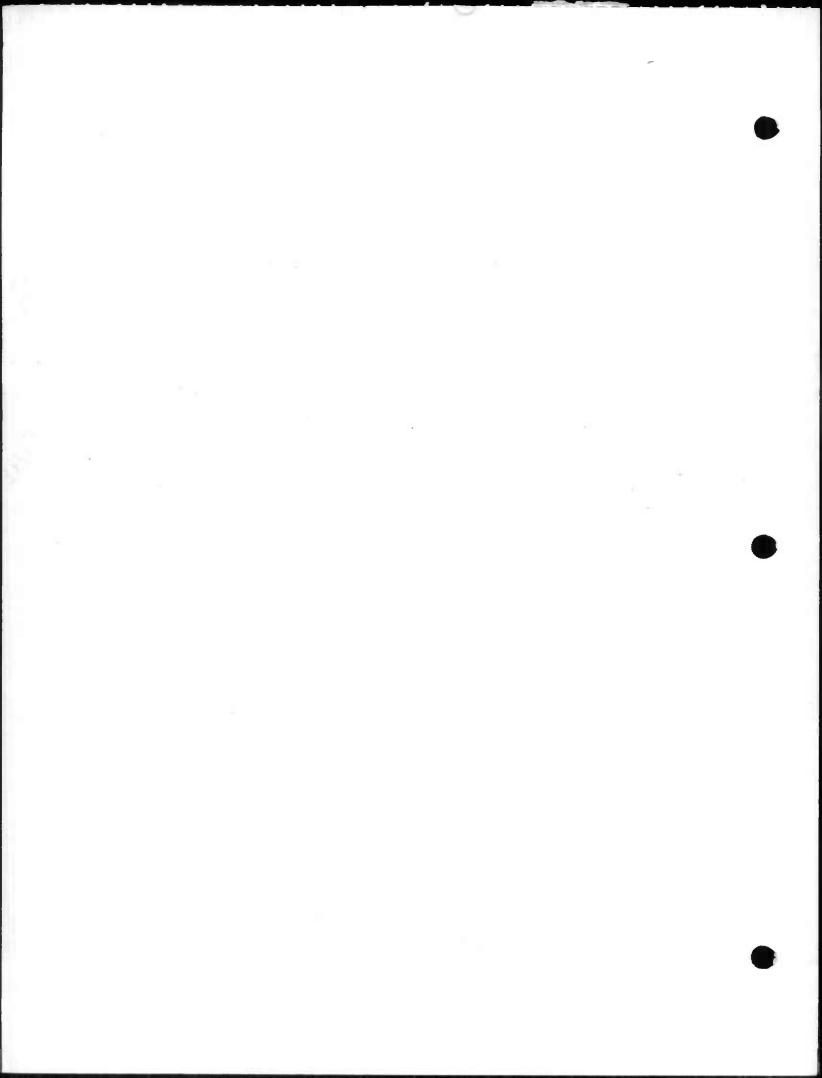
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JUN 2 2

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JUNE 18, PAY 1995 EAR William Joseph Perkins 1042 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Dey, Year) 6. BIRTHPLACE (State or Foreign Country)
Dec. 29,1932 Washington, DC 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS M 2 □ F YRS. 62 579-42-3790 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH permit, Pages 1, 2, 3 ; DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Edgewater 10e. STATE 10d. INSIDE CITY Anne Arundel MD 1 X YES 2 NO FUNERAL 100. STREET AND NUMBER 10f. ZIP CODE 10a CITIZEN OF WHAT COUNTRY? 3565 South River Terrace 21037 USA burial-transit the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-**MARYLAND 21215-0020** FORCES? 1 YES 2 NO yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 TYES 2 NO Specify: White BY Specify 3 Widowed 4 Divorced use as the COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) page 5 should be detached for Elementery/Secondary (0-12) College (1-4 or 5 +) Bus Driver Bd. of Ed. Transportation 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Carrie Nichols Joseph Clemeul Perkins ŧ retained by notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Edna L. Perkins 3565 South River Terrace, Edgewater, MD 21027 BALTIMORE. nours after death. Page 6 may be Pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Burisi 2 Cremetion 3 Removal from State

Donetion 5 Other (Specify) must the funeral director, Maryland Veterans Cem. 6/22 Crownsville, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD medical 23. PART I. Enter the diseases, or complications that ceueed the death. Do not enter the mode of dying, such as cardiec or respiratory strest, filled in by Approximate shock, or haert failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the and completely filled burial, cremation, disease or condition reculting in death) executed within event, OUE TO (OR AS A CONSEQUENCE OF): WOON CANSER traumatic CERTIFICATION Sequentially list conditions, prior to 1 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to certificate be other t CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST 10 the death Injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? this certificate has been signed by with the State Dept. of Health and The law requires that any 1 TYES 2 NO Shows 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item OTHER: OR ATTENDING PHYSICIAN: 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF OEATH

1 Natural 5
2 Accident 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 5 Pending Investigation DIRECTOR: After the hours after death v 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 datermined Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. ) THE HOSPITAL (
) THE FUNERAL E
; filed within 72 h (Check only one) basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and m 29b. SIGNATURE NO TITLE OF CENT 29 LUCENSE, NUMBER 29d. DATE SIGNED (Month BE 222 2



BALTIMORE, MARYLAND 21215-0020

TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attendi	OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it		
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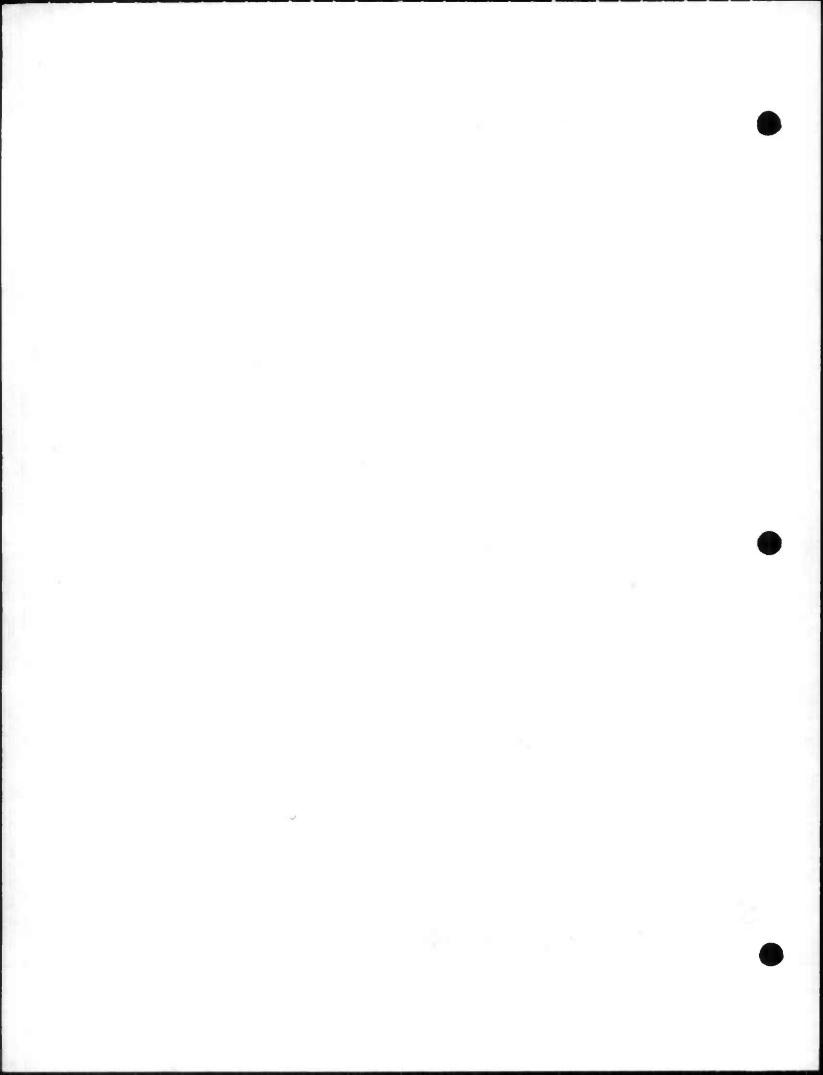
DIVISION OF VITAL RECORDS, P.O. BOX 68760

,		FOR		JUL 1633 -				90	10049
		1 - STATE REGISTRAR	STATE OF MARYL		ICATE OF		NTAL HYGIENE REG. NO.		
		1. OECEOENT'S NAME (First, Middle, Last)  BYRON			Deer		DATE OF OEATH MONTH DAY	YEAR	
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(in yrs. lest birthday)	REEI	7	JUNE 20	1	18:25 P M
pin		213-92-3392 9n. FACILITY NAME (If not institution, give str	1303 2 G F	16 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6 – 28 – 78	Cou	MD
3 should	Œ	600 BLK. YALE				OR LOCATION OF DEATH	9	e. COUNTY OF	OEATH
7, 2,	CTOR	RESIDENCE OF DECEDENT			BALT	IMORE		_A/A	
physician. burial-transit permit. Pages	DIRE	MD Ba:	ltimore	10c. CIT	Randa	11stown		,	10d. INSIDE CITY LIMITS? 1 YES 2 NO
perm	3AL	10e. STREET AND NUMBER			10	Of. ZIP CODE	1	iog. CITIZEN O	F WHAT COUNTRY?
an. transit	FUNER	1960 Woodlawi				21.207			SA
physician. burial-tran	COMPLETED BY FU	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 <b>N</b> 1907	If yes, s	CENDENT OF HISPANIC ( pecify Cuban, Mexican, Pr	PRIGIN? (Specify Yes or verto Rican, etc.)	No- 14. R/	ACE — American Indian, lack, White, etc.
		3 Widowed 4 Divorced	IF YES, OIVE WAR OR DA	ATES	1 🗆 YES	S 2 17 NO Specify:		Sp	Black
r attending use as the		15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(Give kind of	USUAL OCCUPATI	ION ost of working	16b, KIND OF BUSIN	ESS/INDUSTRY	,
4 2 2		Elementary/Secondary (0-12)	College (1-4 or 5+)	Itte. Do NOT u	se retired.)	•	195	,	
the hospital detached fo		8th 17. FATHER'S NAME (First, Middle, Last)		Stud	ent	10 MOTHED'S NAME	First, Middle, Maiden Sur	n/a	
3 B 6	ш	Willie Reed,	Jr				ımpkins	mama)	
5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural Route		State, Zip Code)	
pe 5	F	Dawn Lumpkins		1960	Wood1	awn Dr. I	BA1to., 1	MD 2	1207
6 may ector, pa must b		20a. METHOD OF DISPOSITION  [Description of Disposi	val from State cam	PLACE AND DATE	ther place)	1		FION — City or	Town, State
हैं हैं है		4 Donation 5 Other (Specify)	ENSEE	ing Mer		PIC IG	5/24 Rai	ndall	stown, MD
ter death. F the funeral wal.		* James	2 mis	nton	Jam		ton & So	ons F	uneral Home MD 21217
n by remember		23. PART I. Enter the diseases, or contact, pr heart failure. L	omplications that caused	I the death. Do r	not enter the me	ode of dying, such as	cerdiac or reapirate	ory arrest,	Approximate
		IMMEDIATE CAUSE (Finel disease or condition					١		Interval Batween Onset and Death
ted within 24 completely fill ial, cremation, event, the		resulting in death)	gun 5	w tok	sund	of He	ad		
e a co	2		DOL TO (ON AS A	CONSECUENCE O	r).				
e be execut sician and c rior to buri traumatic	CERTIFICATION	Sequentially flat conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							
6 5 4	S	CAUSE (Disease or Injury							
ding lygier off	E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):				
deatl afte ental	CE	d.							
by the and Me	CAL	PART ii. Other algnificent conditions	contributing to death be	ut not resulting	in the underlyin	g cause given in Pari	i. 24a. WAS AN AUT PERFORME		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
requires that een signed by of Health an shows any	EDI						1 VES 2	NO	DF DEATH2
> 0 = -	PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DFATH YE	S I NO I	UNCERTAIN [	٦		1 N YES 2 INO
has De	IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT					
SICIAN: The certificate h the State l	YSIC	-1. F	HOSPITAL: 1   Inpetient 2   ER/Output	etlent 3 DOA	OTHER: 4  Nursing Hore	ne 5 🗆 Residence 6 💢	Other (Specify) ON	STRE	ET
PHYSIC this ce with th	PH	27. MANNER OF DEATH  1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	JURY AT 280	DESCRIBE HOW INJU		
DING PHYS After this c death with s marked,	ВУ	2 Accident Investigation	6 2 0 95 280. PLACE OF INJURY	1815		YES 2 NO	SUBS ECT		
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St Item 28 Is marked, or It	ED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Speci	ffy)	reset, tactory, offic		City or Town, State)		
DIRE Tem	LE	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowle	21 -					BACTIMECE MD
3 70 -	COMPLETED		: On the beals of exemination						o(s) and manner as stated.
TO THE HOSPITA TO THE FUNERA De filed within 72 IMPORTANT: II	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER	29		ED (Month, Day, Year)
5 5 5 W	0	30. NAME AND ADDRESS OF PERSON WHO	MAN COMPLETED CALLS	TH STEM AC (C	Portant)	OCME		JUN	E 21, 1995
		MARLOR D	Kolen MD.			et, Balt:	imore, M	arvla	nd 21201
			The second second						

OHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020	hours are death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the function property filled in by the filled in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or immost	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 heurs and death. Page is may be intained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me if be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1. DECEDENT'S NAME (First		Ga	ry Wayr	e Ros	eborous	F DEA	-		REG. NO			3. TIME OF DEATH
- 18	-130.5 M		Rose	DOUG.	h		,	06 /3				95	9:04 P
	4. SOCIAL SECURITY NUMBER 213-76-494	9	6. SEX	6. AGE (In 775.	lest birthday) YRS.	IF UNDER 1 YEA		R 24 HRS, MIN.	7. DATE OF BIRTH 9-23-58  B. BIRTHPLACE (State or F Country) MD			IPLACE (State or Foreign	
OR	UNIVERSITY HOSPITAL CENTER				9ь. СІТУ, ТОМ ВА	LTIM		EATH		9c. COUNTY OF DEATH N/A			
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 1			10c. CIT	Y, TOWN OR LO	CATION						10d, INSIDE CITY	
III.	MD		N/A			BALTIM		CIT	Y				LIMITS?
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≝╟	957 N.	CHEST	12. WAS DECEDEN	T EVED IN U.S.	ADMED	12 986		1205		N? (Specify Yes		U.S.	
BY FU	1 Never Married 2  3 Wildowed 4 Divo		FORCES? 1	YES 2	No	If yes,	apocity Cubi	ın, Maxica	in, Puerto	N7 (Specify Yea Rican, etc.)	or No-		— American Indian, c, Whita, atc.
EIED		EDENT'S EDU		16a.	DECEDENT'S	USUAL OCCUPA	TION		164	. KIND OF BUS	SINESS/IN		
COMPLET	Elementary/Secondary (0		College (1-4 or 5-N/A	*)		work done during ne retired.)	most or world	ng	J	OHNS	HOP	KINS	HOSPITAI
SE CO	17. FATHER'S NAME (First, M CHARLIE	. ,	SEBOROU	JGH				HER'S NA		Middle, Malden	Surname) URB	EAN	
2	CHARLIE B		EBOROUG			E. LA							MD.21213
ì	29s. METHOD OF DISPOSITI	n 3 🗆 Rem	ovel from State	20b. PLAC	EANDDATE	OF DISPOSITION	Name of		DAT			City or To	
ŀ	4 Donation 5 Other (Specify) MT. ZION CEMETERY 6/20 LANSDOWNE, MD							, MD					
	· FULL	esler	1/10	MALI	tu								L HOME, MD21213
	23. PART I chtar the di Hock, or he IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart tallure.	a. H	V	ne.		node of dy	ing, suc	h as car	diac or reapi	ratory ar	reat,	Approximata Interval Between Onset and Dast
CENTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  LOG Cycla Cycl												
Sen I	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY 24b, W						given in	Part I.	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE	
الي	PART II. Other algnifica	nt condition				1 □ YES 2 PNO COMPLETION OF DEATH?						THE STREET PLY	
الي							-						1   YES 2   NO
MEDICAL	DID TOBACCO U	SE CONTI						ERTAI	1 B				
MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?	SE CONTI	RIBUTE TO CA	28. PL	ACE OF DEAT	H (Check only or	•)						
MEDICAL	DID TOBACCO U	SE CONTI	RIBUTE TO CA	28. PL	3 DOA	H (Check only or OTHER: 4 - Nursing H	o) ome 5 🗆 Ra		6 Othe	or (Specify)			
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O BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO U  25. WAS CASE REFERRED TO EXAMINER? 1	Pending mestigation Could not be determined IFYING PHYSIC CAL EXAMINED	PRIBUTE TO CA  HOSPITAL: 1 be inpartent 2 28a. DATE OF (Month, D 28a. PLACE Of building, CIAN: To the best of 63: On the basis of 63:	28. PL  ER/Outpatient INJURY ay, Year)  FINJURY — All atc. (Specify)  my knowledge, teamination and/o	ACE OF DEAT  3 DOA  28b. TIM  INJ  home, tarm, 4  death occurrer investigation	H (Check only or OTHER: 4   Nursing H E OF URY M 1   street, factory, of od at the time, di n, in my opinion	ome 5 Re NJURY AT VORK?  YES 2 Titles  Itel and place death occur	NO NO	6 Other 28d, DE 28t, LOG City to the cattime, date	or (Specify) SCRIBE HOW II ATION (Street a or Town, State)	nd Number	r or Rural R ted.	1 TYES 2 (PAÑO



Pages 1, 2, 3 should

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and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal.

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IMPORTANT: 1

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Page 6 may be retained by the hospital or attending physician.

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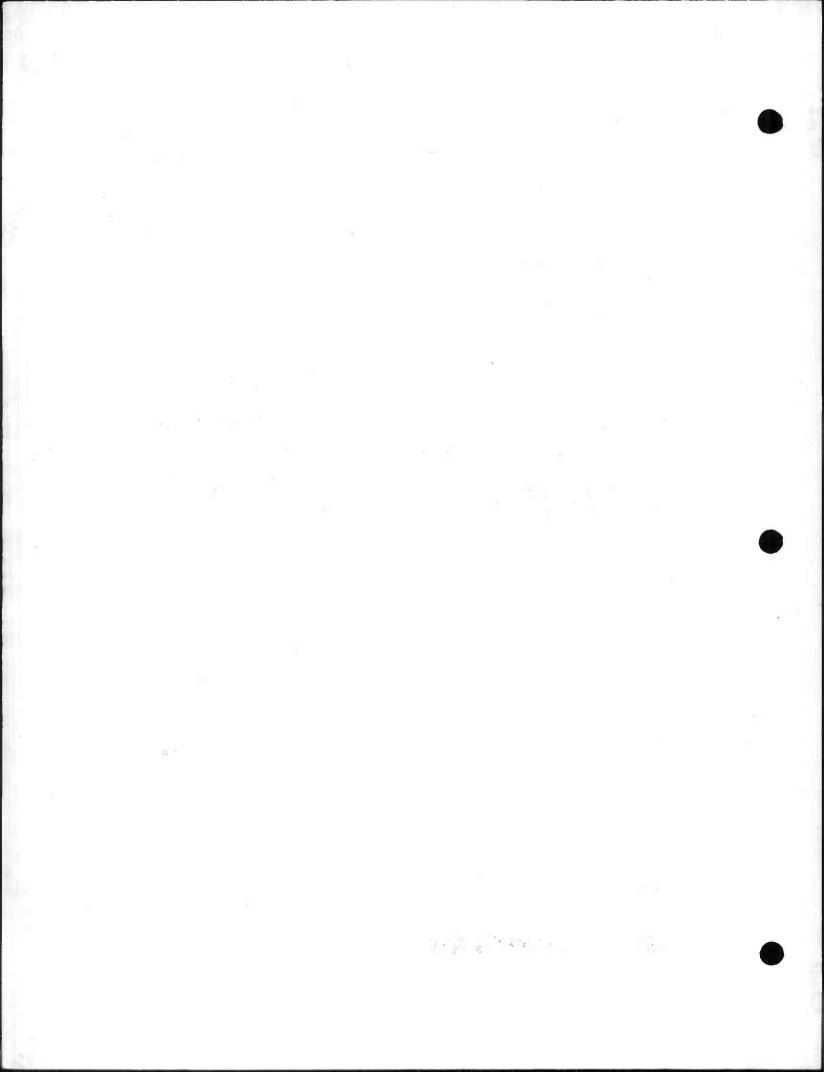
BALTIMORE, MARYLAND 21215-0020

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/29/95 t.t

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Μ. MICHAEL RUMNEY JUNE 18 995 1:50 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOURS 219-88-8688 1 X M 2 - F 20 VBS FEB 17 Maryland Sa. FACILITY NAME (If not institution, give etreet 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR UNIVERSITY HOSPITAL BALTIMORE CITY N/A 10a. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. N/A Baltimore 1 YES 2 NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 314 S. Calhoun St. 21223 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuber, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 X Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) N/A Never Worked N/A 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME /First Middle Maiden Surname Robert M. Rumney, Jr. Annie R. Johnson BE INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert Rumney 316 S. Calhoun St., Balto. Md. 204 METHOD OF DISPOSITION W.Xilburial 2 D Compilison 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State remetery, cremetory or other place) Meadowridge Memorial Park 6/21 Elkridge, Md. 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 23. PART I. Enter the di omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between lat only one cause on each line. IMMEDIATE CAUSE VFIRM Onset and Death disease or condition COCAINE AND NARCOTIC INTOXICATION resulting in death) DUE TO (DR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DE): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a WAS AN AUTOPSY YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Boxed{1}\) UNCERTAIN \( \Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) EXAMINER? HOSPITAL: 1 | Inpetient 2 | ER/Outpetient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28c. INJURY AT WORK7 28b. TIME DF 28d. DESCRIBE NOW INJURY OCCURED FOUND 6-18-95 1 Natural 11:00 AM ΒY 2 Accident 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Num City or Town, Stete) 314 3 Suicide nber or Rural Route Number, S. CALHOUN ST. 6 XXCould not be COMPLETED 4 Homicide determined FOUND: RESIDENCE BALTIMORE. MD. 1 \_\_\_ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. (Check only one) MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ee stated. 296. SIGNATURE AND TITLE DE CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ▶ JUNE 19,1995 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Type, Print))
Penn Street, Baltimore, Maryland 21201

DIVISION OF VITAL RECORDS, P.O. BOX 68760 The OR ATTENDING



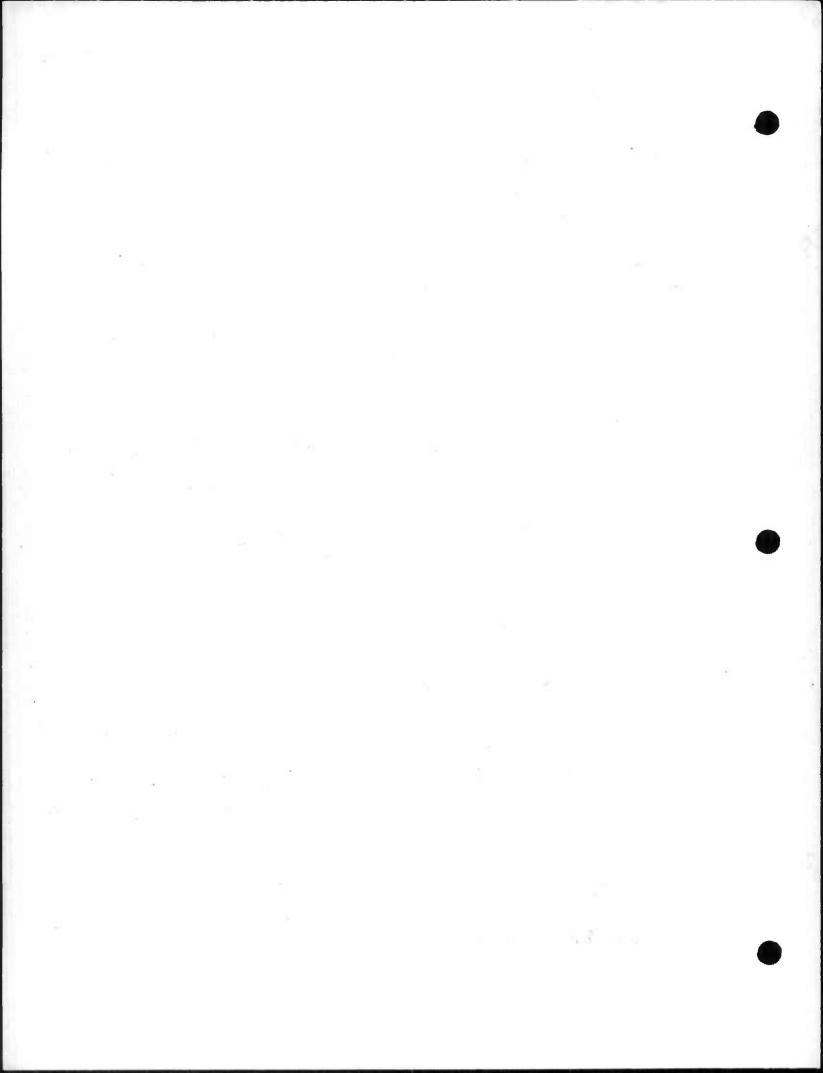
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an and death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within TO bunal with the State Dapt. of Health and Mental Hygien prior to bunal, cremation, or removal.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1

SOON SCORET MARKED TO A SECOND TO THE STATE OF THE SECOND TO THE STATE OF THE SECOND TO THE SECOND T		1. DECEDENT'S NAME (FIST, MIDDIE, LAST)	1		,	2. DATE OF DEATH D	AY YE	AR 3. TIME OF DEATH		
BOOD TO STATE AND AND A STATE					K	June 18	1995	2315 "		
18. SCOUNTY OF BEATH  18. SCOUNTY OF BEATH						(Month, Day, Year)		SIRTNPLACE (State or Foreign Country)		
BE COUNTY OF DEETH   Se. COUNTY OF DEETH   S		216 87 1344 1 M2 DF	20 YRS.	UNITED DATE	HOURS WIN.	6-9-	- 75			
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18. INCORPORT'S EDUCATION   18. INCORPORT'S EDUCATION   18. INCORPORT'S INCORPORT STORY OF STATE OF		IF YES, GIVE WAR OR				,		~ //		
The COLOR CO		45 DECERPINA EDUCATION						Pradia		
The COLOR CO		(Specify only highest grade completed)	(Give kind of wor	SUAL OCCUPATION rk done during most	of working	16b. KIND OF BU	SINESS/INDUST	RY		
The COLOR CO	1 2	Elementary/Secondary (0-12) College (1-4 or 5 +)	1 , /			N.	49			
The COLOR CO	N N	ST EATHER'S MARKE (Fine Addition Local)	7/100							
The DODGE COURSE CONTRIBUTE TO CAUSE OF DEATH YES   No   UNCERTAIN		WALLSO POOL			16. MOTHER'S NAM	E (First, Middle, Maiden	Sumame)			
20. PLACE ANDDATE OF DISPOSITION   Removal from State   20. PLACE ANDDATE OF DISPOSITION   Removal from State   20. PLACE ANDDATE OF DISPOSITION   Removal from State   22. NAME AND ADDRESS OF FRACILITY   Removal from State   23. NAME AND ADDRESS OF FRACILITY   Removal from State	B	THE INFORMATION NAME OF PARTY.					ALGU	DELL		
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23. PART I. Enter the diseases, or complications that causer the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death disease or condition, resulting in death)  Note TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUE		7 11 01		1 1	ADDRESS OF FACI	21/	1000	IN P. T. la		
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PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    24a. WAS AN AUTOPSY PERFORMEDY   1 YES 2 NO   24b. WERE AUTOPSY PINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE DEATH YES   NO   UNCERTAIN   1 YES 2 NO   1 Y	E E	d								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  26. PLACE OF DEATH (Check only one)  EXAMINERY  1   YES 2   NO  THER: 1   Inpetent 2   ER/Outpetent 3   DOA   4   Nursing Nome 5   Realdence & Other (Specify) On Street  27. MANNER OF DEATN  1   Netural 5   Panding Investigation 2   Accident Nome, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street of Injury Allowing, Decident Street, Signature Allowing, Decident Street, Signature Allowing, Decident Street, Signature Allowing, Decident Street, Signature Allowing, Decident Street, Signature Allowing, Decident Street, Death Oct.  290. SIGNATURE AND TITLE OF CERTIFIER  290. SIGNATURE AND ACCIDENT SIGNATURE OF DEATH (TEM 27) (Type, Print)  Theodore M. King, MD. 1111 Penn Street, Baltimore, Maryland 21201		PART II. Other significant conditions contributing to death	but not resulting in	the underlying	cause given in P	ert I 24a WEG AN	Airmoney	ALL WERE ALTORAY PHIRADO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DELICATION DEDICAL  28. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   Nestural   1   Inpettent 2   ER/Outpettent 3   DOA   4   Nursing Nome 5   Residence & Nother (Specify) On Street  27. MANNER OF DEATN  1   Netural   5   Pending Investigation   28e. DATE OF INJURY   28b. TIME OF INJURY   28c. INJURY AT WORK?  2   Accident Investigation   28e. PLACE OF INJURY   Al home, farm, street, factory, office   28l. LOCATION (Street and Number or Pural Route Number, City or Rown, State)   28e. PLACE OF INJURY - Al home, farm, street, factory, office   28l. LOCATION (Street and Number or Pural Route Number, City or Rown, State)   28e. CERTIFFIER (Check only one)   2   MEDICAL EXAMINER: On the basis of azamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.  29e. LICENSE NUMBER   29e. LICENSE NUMBER   29e. DATE SIGNED (Month), Day, Year)   30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)   The Odore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201	8			and and any mig	adda gron in r	PERFOR	IMED?	AVAILABLE PRIOR TO		
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25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Nome 5   Realdence 6   Other (Specify)   On Street    27. MANNER OF DEATN   1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Nome 5   Realdence 6   Other (Specify)   On Street    28. DATE OF INJURY AT WORK?   28d. INJURY AT WORK?   28d. DESCRIBE NOW INJURY OCCURED    28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   1   YES 2   NO   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   INJURY   28d. DESCRIBE NOW INJURY OCCURED   28d. DESCR	Σ	DID TORACCO LICE CONTRIBUTE TO CALLCE	OF DEATH VEC			_   `		1 YES 2 NO		
2 Accident Investigation 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — All home, farm, street, factory, office building, atc. (Specify)  29e. CERTIFIER (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  30. NAME AND AGORESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201  31. DATE FILED (Month, Day, Wear)  32 PEGISTBAR'S SIGNATURE.	AN				UNCERIAIN			`		
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29a. CERTIFIER (Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER  29b. SIGNATURE AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  Theodore M. King, MD.  31. DATE FILED (Month, Day, War)  32 DATE FILED (Month, Day, War)  32 DATE FILED (Month, Day, War)  32 DATE FILED (Month, Day, War)  32 DATE FILED (Month, Day, War)  33 DATE FILED (Month, Day, War)  34 DATE FILED (Month, Day, War)  32 DATE FILED (Month, Day, War)  33 DATE FILED (Month, Day, War)  34 DATE FILED (Month, Day, War)			ecify)	eet, inctory, office			and Number or Ri	ural Route Number,		
296. SIGNATURI AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  329d. DATE SIGNATURI 296. Print)  Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201		on comments	_				st Non	th fort spee		
296. SIGNATURI AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  329d. DATE SIGNATURI 296. Print)  Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201	MP.	(Check only   CERTIFYING PHYSICIAN: To the beat of my kno	wiedge, death occurred	at the time, data as	nd place, and due to	the cause(s) and man	nor se steled.	(toward, May)		
296. SIGNATURI AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. LICENSE NUMBER  329d. DATE SIGNATURI 296. Print)  Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201	į į	2 AMEDICAL EXAMINER: On the basis of examinat	ion end/or investigation,	in my opinion, dea	th occured at the til	me, date and place, an	d dua to the cau	use(s) and manner as stated.		
Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201		29b. SIGNATURE AND TITLE OF CERTIFIER		1	29c. LICENSE NUMB	ER	29d. DATE SIG	INED (Month, Day, Year)		
Theodore M. King, MD. 111 Penn Street, Baltimore, Maryland 21201		Reoder M. King	my)		O.C.M	.E.	<b>▶</b> J11	ne 19 1995		
31. DATE FILED (Month, Day, Year) 32 DEGISTERS SIGNATIVE	F	30. MAME AND AGORESS OF PERSON WNO COMPLETED CAUSE OF D	EATN (ITEM 27) (Type, Pr	rint)						
31. DATE FILED (Month, Day, Year) 32/REGISTMAR'S RIGNATIVE			111 Pe	nn Stre	eet, Ba	ltimore	Marv	land 21201		
		31. DATE FILED (Month, Day, Year)  11. N 2 2 1995			•					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

	712-1017-011		<u> </u>	-11111	CAIL	. 01	DEA		H	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF				3. TIME OF DEATH
1	ANTONIO	CURTIS	SCOT	Т				ı	MONTH	17		YEAR	11;55 A M
1	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las		IE IMPLE	+ VEAS	ar (name	04 (400)	JUNE 7. DATE OF S	17,	1990		
					IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	(Month, De	v. Year)		Country	PLACE (State or Foreign
1	219-72-7052	1 X M 2 □ F	36	YRS.					MAR.9	,195	9	BAL	TIMORE, MD
	99. FACILITY NAME (If not institution, give si	reet end number)			9b. CITY,	TOWN	R LOCATIO	ON OF DE				NTY OF D	
5	4728 WAKEFIELD ROAD						BALTI	MORE	CIT	٧			n/a
K	RESIDENCE OF DECEDENT	. 1220 107					DAL 1	LITOINL	- 011				1/ α
4728 WAKEFIELD ROAD BALTIMORE CITY  RESIDENCE OF DECEDENT  100. STATE  MARYLAND  102. CITY, TOWN OR LOCATION  BALTIMORE  BALTIMORE							T	10d. INSIDE CITY					
뜻	MARYLAND	n/a					BALTI	MORE				- 1	V.V.LIMITS?
	10e. STREET AND NUMBER	.1/ 0							-				YES 2 NO
FUNERAL						101	ZIP CODE						HAT COUNTRY?
ш	4728 WAKE	FIELD ROAD	)				2	21216	5		UN:	ITED	STATES
5	11. MARITAL STATUS	12. WAS DECEDENT EV			13. V	NAS DEC	ENDENT O	F HISPAN	IC ORIGIN? (S	pecify Yee	or No-	14. RACE	- American Indian,
	X Never Married 2 Married	FORCES? 1 [	YES 2	10	- 11	yes, sp	ecify Cubin	n, Mexican	, Puerto Ricar	, etc.)		Black	, White, etc.
A	3 Widowed 4 Divorced	IN TES, GIVE VIEW	ON DATES		'	☐ YES	2 DKMO	Specify.				Specif	» BLACK
0	15. DECEDENT'S EDUC	CATION	tile De	CEDENT'S	LISUAL OC	CHIDAT	NA .		404 - 1710	D OF 8115	INESS/INI	DURTEN	
	(Specify only highest grade	completed)	(G	he kind of v Do NOT us	vork done d	furing mo	st of workin	g	100, KIN	UP BUS	INI ESS/INI	MICO	
ا يّ	Elementery/Secondary (0-12)	College (1-4 or 5+)							0	CNT	TOL O	· V	
\ \	G.E.D.		S	elf-e	inh 10	yea				12 MF	TOLO	2 Y	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAM	AE (First, Middl	, Malden	Surname)		
	JOSEPH BL	IRROUGH						MAC	DA SCI	TTC			
BE	19e. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS	(Street a	nd Number		oute Number, C		Ctota 74	Code)	
임	MADA SCOTT		1		728								MD ant and
							AKEFI	LELU	KUA				MD apt.204
	20e, METHOD OF DISPOSITION  X	oval from State	20b. PLACE	ND DATE O	P DISPOSI	TION (Na	me of		OATE	20c. LO	CATION -	City or Ton	wn, State
	4 Donation 5 Dother (Specify)		ÄRBU	TÜŚ	MEMO	RIA	L PA	<b>ARK</b>	6-22	Al	RBUTI	JS. M	IARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE / D			22. 1	NAME A	O ADDRES	S OF FAC	HLITY	**			
		108			t <sub>a</sub> l	IM i	_ M/	/DCH	FH13	l 01	E	IND TH	AVENUE
	- / tower	1-te	VX		The same of								AVLINUE
	23. PART I. Enter the diseases, or or	omplications that ca	used tha de	eth. Do n	ot anter	tha mo	de of dyi	ng, auch	aa cardiac	or reapi	ratory an	rest,	Approximata
	ahock, or haart failure. (	LIST ONLY ON A CAUSE	on each iina	. 17									interval Between Onset and Death
		0 -	1 0	1.6									Onset and Death
	reaulting in dasth)	. Rena	Ta	LLU	re								5 mos.
		1.			,								10
Z	Sequentially list conditions,	DUE TO (OR	neph	ros	Dat	hy							10 mos.
Ĕ	if any, leading to immediate	DUE TO (OR	AS A CÓNSEC	NENCE OF	7:	- (							
CERTIFICATION	CAUSE (Disease or injury	·											
	that initiated events	OUE TO (OR	AS A CONSEC	DUENCE OF	7):	-							
E	resulting in daeth) LAST												
빙													+
	PART ii. Other significant conditions	contributing to das	th but not r	asuiting i	n the un	derlying	cause g	iven in F	Part i. 24a	WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL	Preumocystic									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
	THE ESTED CO 311	3 (001)111	1 121	eur	r (ON)	100			10	YES 2	M, NO		OF OEATH?
													1 TES 2 NO
ž I	DID TOBACCO USE CONTR	IBUTE TO CAUS	E OF DEA	TH YE	S D N	10 X	UNC	ERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLAC	E OF DEAT	H (Check o	nly one)							
ĭs ∥	1 ☐ YES 2 № NO	HOSPITAL: 1   Inpatient 2   ER	Outpetient 1	DOA	OTHER		6 50°0-	eldense d	5 Other (Sp	no/6.1			
<u> </u>	27. MANNER OF DEATH	26e. DATE OF INJU		28b. TIM		28c. INJ		miderice (	-	- 77	111111111111111111111111111111111111111	OUBET	
	1 Natural 5 Pending	(Month, Day, Y	oar)		DRY	WO	RK?		28d, DESCRIE	E NUW II	WUNT OC	CUMED	
┢	2 Acoldent Investigation	NA		NA	М		ES 2 🔀	NO	NA				
ا ۵	3 Suicide 6 Could not be	28e. PLACE OF IN. building, etc.	JURY - At hor (Specify)	me, farm, s	treet, facto	ry, office	,		28f. LOCATIO City or To	(Street e	nd Number	or Rural A	oute Number,
2	4 Homicide determined	N	A						Only or 10	vii, Olete)			
۱ ۳	29e. CERTIFIER	MAN. To P.											
윷║	(Check only one)												
COMPLETE	2 MEDICAL EXAMINE	t: On the baels of examination	nation end/or I	nvestigatio	n, in my op	oinion, d	eath occur	ed at the t	lme, date end	place, end	due to th	e cause(e)	end menner se stated.
o U	296. SIGNATURE AND TITLE OF CERTIFIER	6 6		1 -	-	_	29c. LICE	NSE NUM	BER		29d, DAT	E SIGNED	(Month, Day, Year)
ص	CFRING THE	1 wllas	20101	de	MI	D.	101	-B			D /	721	195
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED COMPLET	ZOULL STORES		0.400		100	57			Y	121	173
	A A	COMPLETED CAUSE O	P OEATH (ITEN	1 27) (Type,	0 0		1	/ 1	10-7	. 11	1	01	D 2122
	HINE MILL	Kaszews	KIN	L-1).	60	0 1	10144	WO	HE B	cult	mo	RM	1) 2128/
	TIPKE DED MO QE YOUR (	के. प्रायमित रह	URE			_							
100													

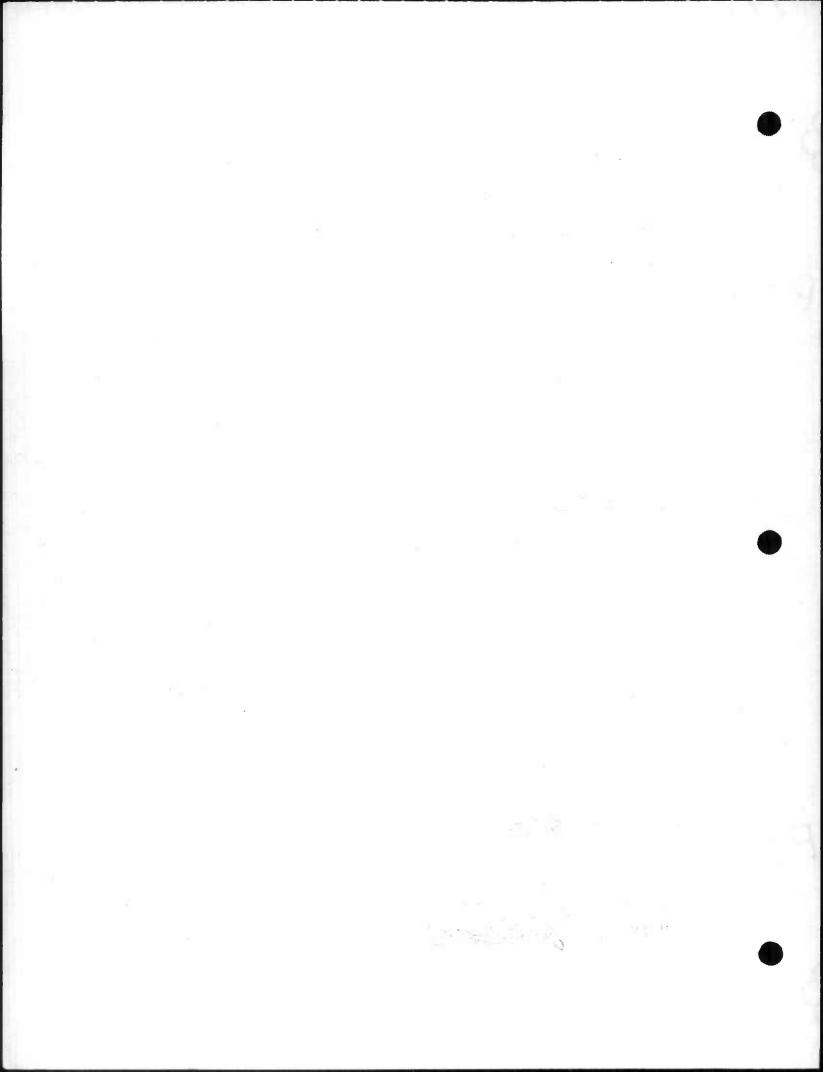
tending physician.

as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

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מביר בונים בירי ווילטור וילים	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	
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	DING	After	filed within 72 hours after death with the State Bent of Health and Mental Hurlane price to hurlal premaries or removal
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	-	$\vdash$	4

CEDENT'S NAME (First, Middle, Last)  MI Orec C  CIAL SECURITY NUMBER  15-10-1745  MCILITY NAME (If not institution, give  OWARD CO. General STATE 106. COUNT  Md. Bal  TREET AND NUMBER  900 Windsor Rd.	s. SEX  1  M 2  F  street and number)  Cal Hospital	n yrs. lest birthdey) 100 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	2. DATE OF DE MONTH  JUNE 7. DATE OF BIF	20 I	YEAR 3. TIME OF DEATH 95 650 F	
CIAL SECURITY NUMBER  15-10-1745  CILITY NAME (If not institution, give  OWARD CO. General IDENCE OF DECEDENT  TATE 106. COUNT  Md. Bal  TREET AND NUMBER	street and number)	n yrs. last birthday)	7		June 7. DATE OF BUT	20 1	985 650 F	
15-10-1745  COLUMN NAME (If not institution, give  OWARD CO. General  IDENCE OF DECEDENT  ITALE  10b. COUNT  Md. Bal  TREET AND NUMBER	al Hospital		7		7. DATE OF BIF	TH	8 BIOTHOLACE (State or Comic	
OWARD (I' not institution, give OWARD CO. GENET HIDENCE OF DECEDENT TATE 106. COUNT Md. Ba] TREET AND NUMBER	street and number) Cal Hospital	100 THS.		HOURS MIN.	(Month, Day,	Year)	Country)	
OWARD CO. GENET IDENCE OF DECEDENT TATE 106. COUNT Md. Bal	ral Hospital	- 1	OL OTTH TOWN		AUG. 17		Maryland	
Md. Ba]	Υ		Columb	OR LOCATION OF D	EATN		ward	
TREET AND NUMBER		10c, CITY	, TOWN OR LOCAT				10d. INSIDE CITY	
TREET AND NUMBER	Ltimore		N/				LIMITS?	
900 Windsor Rd.	CIMOLC			I. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?	
				21208			USA	
ARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		ENDENT OF HISPA			14. RACE — American Indian,	
1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				2 NO Speci		H(C.)	Black, White, atc. Specify:	
15. DECEDENT'S EDU	JCATION	16a. DECEDENT'S U	DECEDENT'S LISHAL OCCUPATION 140 KIND OF				white	
		(Give kind of w	ork done during ma	est of working	100. 1110	OF BUSINESS/INOU	9111	
12	3	Bank I	Investia	ator		Ranking		
	evenson, Sr.			Laura	E. War	d		
turial 2 Commetter 3 - Rem	noyal from State 20b.	PLACE AND DATE O	FDISPOSITION (Na	ime of	6/2C	ROC. LOCATION — CI	ity or Town, State	
11 3	1	CLISTIE			ACILITY	crisiiei	J, Md.	
14/1///		~	Gary L	. Kaufma	n Funer	al Home	of Elk., Inc	
17001			5695 M	ain St.,	Elkrid	ge, Md.	21227	
EDIATE CAUSE (Final see or condition ting in death)	a. Aspiration Due to (or as a	Pheur Consequence of					Interval Betwoen and D	
entially list conditions,	b. ESONOGE ()	CONSEQUENCE OF	):			0.0	1 year	
e. Entar UNDERLYING	С					*		
initiated evanta	DUE TO (OR AS A	CONSEQUENCE OF	NSEQUENCE OF):					
	d							
ii. Other algnificant condition	ne contributing to death bu	it not reaulting in	tha underlying	g cause givan in	Part i. 24a. V		24b. WERE AUTOPSY FIND	
triol Fibrillation,	Hypothymic	Vism, D	ementia			THE CHIMED!	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH?	
						/(	1 TES 2 NO	
				UNCERTAI	NX			
(AMINER?	HOSPITAL:							
Natural 5 Pending	(Month, Day, Year)		IRY WO	RK?	286. DESCRIBE	NOW INJURY OCCU	RED	
Sulatida	26s. PLACE OF INJURY	At home, farm, st			281, LOCATION	Street and Number of	r Rural Route Number.	
	building, atc. (Special	(Y)			City or Town	, State)		
ERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my knowle	dga, death occurred	d at the time, date	end place, and dus	to the cause(s) a	nd menner se stated	1.	
GNATURE AND TITLE OF CERTIFIE	Pr 1			29c. LICENSE NU	MBER	29d, DATE S	SIGNED (Month, Day, Year)	
to be he	on, 11,	7		1146120		▶JUN	ne 20 1995	
- // ^	-000	TH (ITEM 27) (Type, I	Print)		240 0	01.1	40 0:0:	
emando Iki	eva 5777	Hurpers	Furn Ro	X, Suite	200-6	-orumbia,	111, 21044	
TE FILED (Month, Day, Year) IN 2 2 1995	20. REGISTRAR'S SIGNA							
	(Specify only highest grade emeritary/Secondary (0-12)  12  THER'S NAME (First, Middle, Lest)  William E. Ste  NFORMANT'S NAME (Type/Print)  Julia S. Bates  THOO OF DEPOSITION  Murial 2 Committee 3 Rem  Donation 5 Other (Specify)  CHATLI. Enter the disease of the committee of t	THER'S NAME (First, Middle, Lest)  William E. Stevenson, Sr.  NEORMANT'S NAME (Type/Print)  Julia S. Bates  ETHOO OF DEPOSITION  Murtal 2 Grantisen 3 Removal from States  Committee Function (Reach)  CONATURE FUNCTION (Reach)  CONATURE FU	Specify only highest grade completed)    Specify only highest grade completed   Give kind of wife. Do NOT use	College (14 or 5 +)   12   3   Bank Investign make the property of the kind of work done during make the property of the pro	Continued   Cont	Comparison of the properties of the conditions   Comparison	(Specify only highest grade completed)  (Specify only highest grade gr	



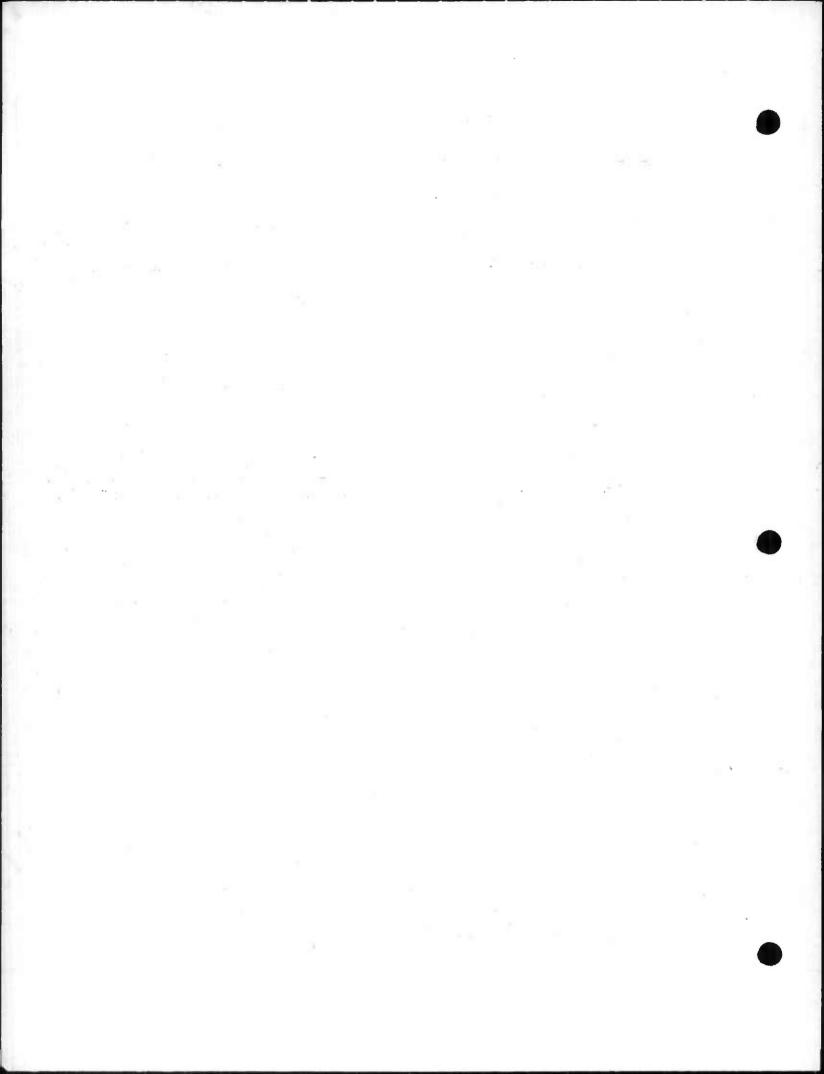
hospital or attending physician. rached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BUCO BE OT	O BE COMPLETED BY PHYSICIAN MEDICAL CEPTIFICATION
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hospi	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hosp

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEA	TH		REG. NO.

	1 - FOR REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL HYGIEN			
	DECEDENT'S NAME (First, Middle, Last)	Naomi M. Sn				2. DATE OF DEATH	AY YEA	3. TIME OF DEATH 9:40 AM	
		1 M 2 D F 7	79 YRS.	FUNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 2.	RTNPLACE (State or Foreign buntry) Maryland		
DIRECTOR	Heritage Meridian		Dund		Baltimore				
	Maryland 106. COUNTY	Baltimore 10c. CITY, TO			Du	ındalk		10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
FUNERAL	2904 Dunbrin Cour	2904 Dunbrin Court Apt. C			101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY United States				
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO TES		city Cuben, Maxica	NIC ORIGIN? (Specify Yes, Puerto Rican, etc.)		IACE — American Indian, Ilack, Whita, atc. pecify: White	
COMPLETED			16a. DECEDENT'S US (Give kind of work life. Do NOT use n Sales (	done during mos stired.)	N st of working	16b. KIND OF BU			
N N	10 Years 17. FATHER'S NAME (First, Middle, Last)		0.0000	7	40 1407145710 1/4	WE (First, Middle, Maiden	rtment.	Stores	
	Louis Thalheimer					h Bennett	Surname)		
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ORESS (Street as		Route Number, City or Tow	m, State, Zip Code	)	
۲	Stephen J. Smell		2617	Liberty	Pkwy 1	Dundalk, M	D 2122	2	
	20a. METHOD OF DISPOSITION  1 Date   20c. LOCATION - City or Town, Sta								
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Gill		7922	Wise Au	neral Home e Dundalk	· Maryl	dalk, Inc. and 21222	
	23. PART I. Énter the diseases, or constances, or heart feiture. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	CERE	ch line. Psono V	BSEN	lan	Ares	DEN	Approximata interval Between Onset and Death	
NO	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
CERTIFICATION	CAUSE (Disease or Injury that initiated events  CAUSE (Disease or Injury that initiated events)							14708.	
ER	resulting in death) LAST								
MEDICAL	PART II. Other significant conditions of the con					PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	20	6. PLACE OF DEATN		ONCERIAII	101			
Sic		OSPITAL: Inpatient 2 ER/Outpat	tient 3 🗆 DOA 🖇	THER: Nursing Home	5 🗆 Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATN  1 💢 Natural 5 Pending 2 Accident Investigation	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME O	WOI	JRY AT RK? ES 2 NO	28d. DESCRIBE NOW	NJURY OCCURED		
	3 Suicide 6 Could not be 4 Homicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify)  28e. PLACE OF INJURY — At home, tarm, street, factory, office City or Yown, State)							ral Route Number,	
COMPLETED		AN: To the best of my knowled On the basis of examination						se(a) and manner as stated.	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Alha	then		29c. LICENSE NUN	S30	29d. DATE SIGN	NED (Month, Day, Year) - 19 - 95	
	ASHOK CHAT	OMPLETÉD CAUSE OF DEAT	3 92	"7 A	NNA	Pous.	Ros	~) ,	
	31. DATE FILED WORD 2 2 1995	32 REGISTINGS SENAT	Market						



JUN 2 2 1995

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Liquete YEAR Shellenberger Theodora CHIEF T ENDED CIED June 18 1995 5:55 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) JF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 X F 212-36-9973 74 Oct. 4 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Franklin Square Hospital Baltimore County Rossville 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk 1 TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 1917 Nevill Road 21222 United States be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried YES 2 NO Specify: BY 3 🔀 Widowed 4 🗌 Divorced Specify: Cuban White 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) 12 Years Waitress Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Manuel Liquete Andres Julia Martin Bravo funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Louk 1925 Nevill Road Dundalk, MD 8 90 s executed within 24 hours after death. Page 6 may in and completely filled in by the funeral director, pag to burial, cremation, or removal. 20a, METHOD OF DISPOSITION

1 🗗 Burlal 2 🗆 Cremation 3 🗀 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must Parkwood Cemetery 6/21/95 4 Donation 8 Other (Specify) Baltimore, MD 21. SIGNATURE OLYFUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 the medical 23. PART I. Enter the discusses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or the first only one cause on each line. Approximals Interval Betw IMMEDIATE CAUSE (Final Onset and Death disesse or condition Chronic Obstuctive Lung Disease resulting in death) event, Years DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the death certificate be the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE amy Bronchitis Bronchopneumonia 1 YES 2 NO OF DEATH? Shows 1 TES 2 NO t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: . OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED 1X Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, lactory, office building, arc. (Specify) 3 Suicide 69 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) ED 4 Homicide 28 determined COMPLET Hem 29a. CERTIFIER 1 🗹 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end menner as stated. FUNERAL ( (Check only one) 900 TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 \_\_ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner es stated. 256. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year) BE Ma arm 18 95 D44604 6 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Suter 9000 Franklin Square Drive Baltimore Md. 21237 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-18 Rev 1/89

**BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witting A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATN

2. DATE OF DEATN

	1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATN		3. TIME OF DEATN
	Berry	Barry	Sm	ith			9 1995	2307 M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN		TTNPLACE (State or Foreign
	216-84-6292	1 € M 2 □ F 3	YRS.	ONTHS DAYS	HOURS MIN.	OCT 26.	963 1	Taryland
۱	Se. FACILITY NAME (If not institution, give s	treet and number)		b. CITY, TOWN O	R LOCATION OF DI	EATH	9c. COUNTY OF	PEATH
6	Shock Trauma	Center		Balti	more		Λ	11A
DIRECTOR	RESIDENCE OF DECEDENT  10g. STATE 10b. COUNTY	At La	10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY
#	Maryland	N/A	12	Saltir	nore			LUMITS?
¥	100. STREET AND NUMBER	14 61	Apt	101.	ZIP COOE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL	410 W. Fran	iklin ST.	7A		21201	1	I U	SA
Ę	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEOENT EVER IN U.S. FORCES? 1 YES 2		13. WAS DEC	ENDENT OF NISPAI	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14. R/	NCE — American Indian, ack, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES				ochy RI.
	15. DECEDENT'S EDUC		DECEDENT'S US	BUAL OCCUPATION	N	16h KIND OF BUI	SINESS/INDUSTRY	PIQCI
once.	(Specify only highest grade Elementagy/Secondary (0-12)	College (1-4 or 5+)	(Give kind of worlde. Do NOT use	k done during mos	of working	1	110	
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at once.	17. FATHER'S NAME (First, Middle, Lagt)	· 11 T.			B. MOTHER'S NA	ME (First, Middle, Malden	Sumame)	
BE BE	VVIIIe or	nih Jr.			_Kul	019 (	lay	
TO BE	19. INFORMANT'S NAME (Type/Print)	44	196. MAILING A	ODRESS (Street at	Number or Rural	Boute Number, City or Tow	n, State, Zip Code)	101011
20	20e. METHOD OF DISPOSITION	20h PLA	TUU D	DISPOSITION (No	Taxi	a. Dar	TD, IVIO	1.2/2/6
or removal.  medical examiner must	1 M Burlet 2 Cremetton 3 Remo	ovel from State committy	Vood	12111	1	6/24/95	CATION - CHY OF	D Md
ner ner	21. SIGNATURE OF FUNERAL SERVICE ALC	EMSEE O. O	1000	22. NAME AN	D ADDRESS OF FA	CILITY	11101	VIII.
Exam	(A) oph	I. XI	11-	Jose	Phul	Kuss F	-uner	a Home
dicai	23. PART  . Enter the disposes, or o	complications that caused the	desth. Do not	enter the mor	le of dylng, suc	has cardled or read	catory arrest	101 10, 21216 Approximata
	shock, or heart fellure.	List only one ceuse on each I	lne.		o or aying, sao	as cardide of teaps	retory arrest,	interval Between Onset and Death
rent, the	disease or condition resulting in death)	Gun she	+ 100	und	ho 1	Abdan a	n	Oliset and Daath
event,	(esciting in death)	DUE TO (DR AS A CON			10 1	7 -0 (0 - 4,2		
atic e	Sequentielly flat conditions,	b						
or other traumatic	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (DR AS A CON	SEOUENCE OF):					
FIC Ne p	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	SEDUENCE OF):					
or other	resulting in death) LAST	4.						
lury, CE	PART II. Other significent condition	a contributing to death but as	et consulting in	the constant of	ANNE SEE 12	I		
S Z S		e contributing to death but no	rc resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
2 K   III						1 PYES 2	□ NO	OF DEATH?
5 4 -	DID TOBACCO USE CONTE	PIRLITE TO CAUSE OF D	ATH VEC		UNCERTAIN			1 TYES 2 NO
item 23 siccials	25. WAS CASE REFERRED TO MEDICAL		ACE OF DEATN		UNCERIAII	10]		
r item	EXAMINER?  1)() YES 2   ND	HOSPITAL: 1   Inpatient 2   XER/Outpatient		THER:	5 Residence	6 Other (Specify)		
PHY	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (	OF 28c. INJL	RY AT	28d. DESCRIBE NOW II	NJURY OCCURED	
BY PH	1 Natural 5 Pending 2 Accident Investigation	6-19-95	1900			Subject	+ Sho	1
0 2	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, atre	el, lactory, office		281. LOCATION (Street a City or Town, State)	and Number or Run	I Route Number,
E W	lan orașina	Street				600 BCK		an St Balt.
7 = =	29a. CERTIFIER (Check only one)	CIAN: To the best of my knowledge,	death occurred	nt the time, data	and place, and due	to the cause(a) and man	ner an stated.	
IMPORTANT:  O BE COA		R: On the beels of examination and/	or investigation,	in my opinion, de	ath occured at the	time, data end place, an	d due to the cause	e(a) and manner as stated.
BE POR	29b. SIGNATURE AND INTLE OF CERTIFIER	1011			29c. LICENSE NUN	ABER	29d. DATE SIGN	ED (Month, Day, Year)
2 ₹	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE DE DEATH (	TEM 270 /2 0	intl	O.C.1	I.E.	June	20 1995
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41	31. DATE FILED MONTH DO NOT TO	A READ TO SURE BIRN COM	A P			Baltimore	. Mary	land 21201
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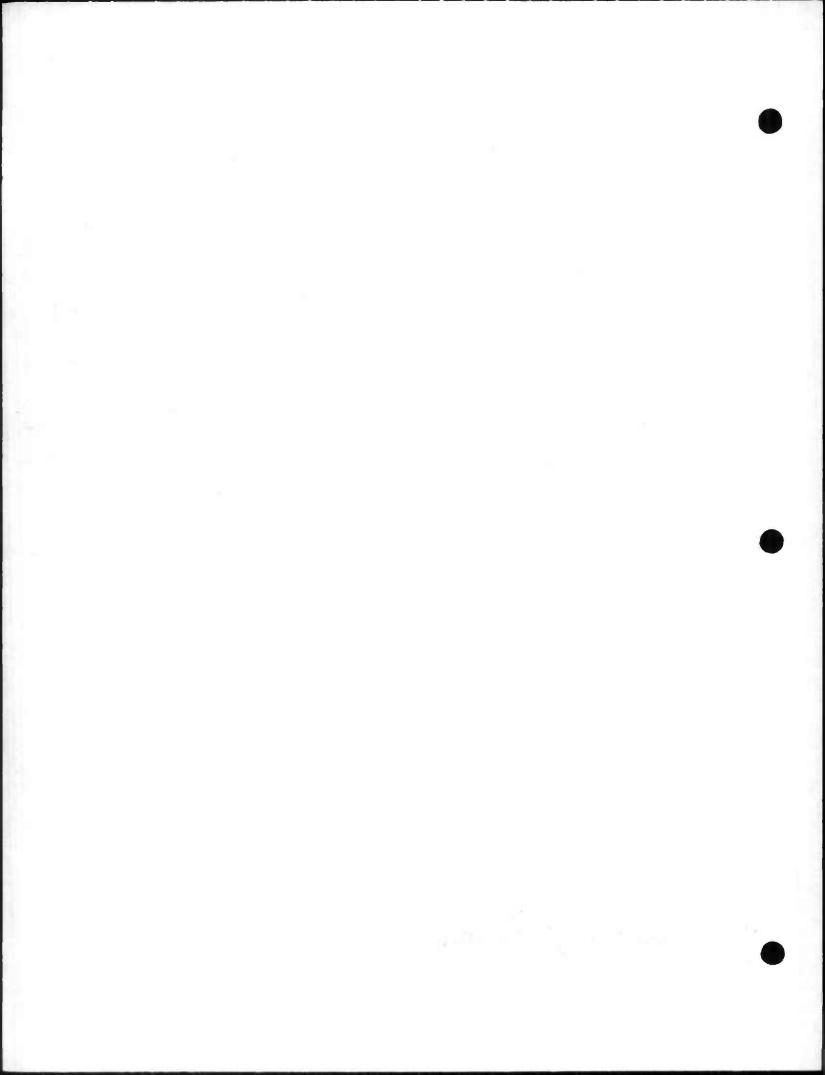
executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal. completely filled in by 6 cremation, this certificate has been signed by the attending physician and com-n with the State Dept. of Health and Mental Hygiene prior to burlal,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH UNE 6. AGE (In yrs. le 5. SEX 7. DATE OF BIRTH Month, Day, Year AUQ 24 IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig Your 4 1 M 2 F DAYS YRS. 94. FACILITY NAME (If not institution, give street and number AP 9c. COUNTY OF DEATH DIRECTOR P timare 10g. STATE 10c. CITY. JOWN OR LOCATION 10d. INSIDE CITY ar OI 1 YES 2 NO FUNERAL 100. STREET AND NUMBE Apt 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or if yea, specify Cylvan, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: --- American Indian, White, etc. 1 Never Married 2 Merried 1 YES IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade e (1-4 or 5+) nentary/Secondary (0-12) notified at once. IT. FATHER'S NAME (First, Middle, Last 8 19e. INFORMANT'S NAME (Typ) 0 20e, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of pe 20c. LOCATION must 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation S ☐ Other (Specify) traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUS Joseph 2 W 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Orunery kuolole reaulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ò any injury, PART II. Other significant equalitions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAKABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2'NO 23 shows nary -mbo 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Z UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Home 5 Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked. 1 Natural Pending Investigation 1 YES 2 NO death v DIRECTOR: After the hours after death BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide BE COMPLETED 8 Could not be determined 28 4 Homicide TO THE HOSPITAL DR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 nation end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end manner es stated VILE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2 RESERVOIR CIRCLE GAKUBA



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	10	1. DECEDENT'S NAME (First, Middle, Last)		Snowde	2N	2. DAT	E OF DEATH TH DAY NA 20 (99	S. TIME OF OEATH
the hospital or attending physician. detached for use as the bunial-transit permit. Pages 1, 2, 3 should once.	3	218-01-0048	5. SEX 6. AGE (In yrs.	YRS. MONTHS	DAYS HOURS	MIN. (Mor	E OF BIRTH 1th, Day, Year) 28 1909	BIRTHPLACE (State or Foreign Syunity) BAITIMONE
	TOR	98. FACILITY NAME (If not Institution, give str Seatow M RESIDENCE OF DECEDENT	and number)	) h. c	TY, TOWN OR LOCATION	MDNE	34	Y OF DEATH
	DIRECTOR	Mary and 106 COUNTY	/A	10c. CITY, TOWN	or LOCATION timo	re	-1	10d, INSIDE CITY LIMITS?  1 VES 2 NO
	FUNERAL	634 Fren	now+ A	very	2 BY	217		N OF WHAT COUNTRY?
	TO BE COMPLETED BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 Tyes IF YES, GIVE WAR OR DATES	ARMED 13	If yes, specify Cuba 1 YES 2 NO.	n, Mexicen, Puerto		RACE — American Indian, Black, White, etc. Specify: Black
		15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) 16a.  College (1-4 or 5+)	DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired.	during most of workin	16	b. KIND OF BUSINESS/INDUS	STRY V
P 2 2		17. FATHER'S NAME (First, Middle, Last)	Snowcle	n	19 U lOCI 1	IER'S NAME (First,	Middle, Maiden Surname)	WOLLEY.
s should		190. INFORMANT'S NAME (TypePrint)	Snowdew	196. MAILING ADDRES	SE (Street and Number	or Rural Route Nur	noor, City or Town, State, Zip C	nore Warelance
may		20e_METHOD OF DISPOSITION 1   Burial 2   Cremation 3   Remove 4   Donation 5   Other (Specify)	cemetery,	CE AND OATE OF DISPO	MTZI	00 6	77 2nll	y or TOWN, State
r death. P e funeral al. examin		21. SIGNATURE OF FUNERAL SERVICE LICE	and	× 1	NAME AND ADDRES	Carr	oll Fune	ral Hone Wenue
be executed within clan and completely filling to burial, cremation, raumatic event, the		23. PART I. Enter the diseases, or co shock, or heart feliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	lat only one cause on each in	rost Co	r tha mode of dyl	ng, auch as car		Approximate interval Between Onset and Daath
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON:			8		V
ending Hygie or oth	ERTIF	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):				
the d	AL C	PART II. Other aignificant conditions		t resulting in the u	indarlying cause g	jiven in Part i.	24a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
requires that the seen signed by of Health and shows any le	MEDIC		amentia				PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO
law re nas bee Dept. o 23 sh		DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL		ATH YES		ERTAIN 🗆		
VITENDING PHYSICIAN: The CTOR: After this certificate hafter death with the State 28 is marked, or item	SICIAN:	EXAMINER?	HOSPITAL: 1   Inpatient 2   ER/Outpatient	ОТН		aldenne 8 🗆 Oth	or (Specific)	
	ву рну	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DE	SCRIBE HOW INJURY OCCU	RED
	ETED B	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, street, fa	ctory, office		CATION (Street and Number or r or Town, State)	Rural Route Number,
NERAL DIRECTOR / NERAL DIRECTOR / NEW 72 hours	COMPLE		AN: To the best of my knowledge, On the basis of examination end/					
TO THE HOSPI TO THE FUNEF be filed within	O BE C	295 SIGNATURE AND TITLE OF CERTIFIER	CMP		29c. LICE	2703°		HIGNED (Month, Day, Year)

who completed cause of Death (ITEM 27) (Type, Print)

PROPERTY AND 5310 Old Court

The Huater 31. DATE FILED (Month, Day, Year) JUN 2 2 1995

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THE HOS	TO THE FUN	be filed with	IMPORTAN	

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Las					2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH	
	Rebecca Sh				JUNE 16	95	1905 M		
OR	4. SOCIAL SECURITY NUMBER 216-01-3330 5. SEX 6. AGE (In yrs. less 90			MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG.10,19	Cour	THPLACE (State or Foreign MARYLAND	
	SINAI HOSPITAL		96. CITY, TOWN BALTIM	OR LOCATION OF DE	ATH	NA DEATH			
ᇤ	RESIDENCE OF DECEDENT  10e, STATE  10b, COU	ITY	10c CI	TY, TOWN OR LOC	TION			10d. INSIDE CITY	
L DIRECTOR	MARYLAND N/A			BALTIMORE			10d. INSI		
FUNERAL	10e. STREET AND NUMBER	ם וחמוג		101. ZIP CODE 21215			10g. CITIZEN OF WHAT COUNTRY? USA		
٣ I	3329 CLARKS LA., APT. D  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. AR								
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<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT o	use retired.)	ost or working	CM	1 cm 1 cm T 3 1	T DI TUD GO	
MP	UNKNOWN		SECRET	ARY				N BLIND CO.	
	17. FATHER'S NAME (First, Middle, Last) ABRAHAM	SHALOWIT	7.			ME (First, Middle, Maiden S	ten Sumame) CAPLAN		
BE	19a. INFORMANT'S NAME (Type/Print)	DILIBONIT		G ADDRESS (Street					
2		MR. MANNES SHALOWITZ 4 PICASSO CT. BALTIMORE, MD 21208							
	20s. METHOD OF DISPOSITION  1 X Jurisi 2 Cremation 3 Re 4 Densition 5 Out (Specify)	emoval from State	etery, crematory or		H_TSRAEL	6/19/95	PAT.TTM	ORE, MD	
- 1	21. SIGNATURE OF TINERAL SERVICE	ucpete		22. NAME A	ND ADDRESS OF FA	CILITY			
	1/km	Dones			EVINSON & REISTERTY	BROS., IN	IC. ILTO, M	0 21215	
	23. PART I. Enter the diseases, a shock, or heart Jeffur	complications that cause	the death. Do	not enter the m	ode of dying, suc	h as cerdiac or reapi	ratory arreat,	Approximate	
	interval Betwee  Onset and Del							Opport and Double	
	disease or condition							hours	
z	disease or condition resulting in death)  Hypovolenic Septic Shock hours  Hypovolenic Septic Shock hours  Obstructing Colon/Redal Carcinona Months  Bequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  CAD 1 C LIE							months	
CERTIFICATION									
5	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE	OF);					
H	resulting in death) LAST	d							
- 11	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS								
SA					g couse given in	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MED								OF DEATH?  1 YES 2 NO	
SICIAN: MEDIC	DID TOBACCO USE CON			ES NO	UNCERTAIN	10			
흥	25. WAS CASE REFERRED TO MEDICAL EXAMINER								
ĭ X	1 VES 2 NO	1 Inpatient 2 ER/Outp		4 - Nursing Ho	ne 5 🗆 Residence				
ву рну	1 Natural 5 Pending	(Month, Day, Year)	26b. TII	JURY W	JURY AT ORK? YES 2 NO	26d. DEŞCRIBE HOW IN	JURY OCCURED	4	
_	3 Suicide 6 Could not b	— Al home, larm,	- Al home, larm, atreet, lactory, offica		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
<b>B</b>	29a. CERTIFIER 1 CERTIFYING PHY								
COMPLETED	(Check only 2   MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, dash occurred at the time, data and place, and due to the cause(a) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER						29d. DATE SIGNE	D (Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print)  MICHAEL J. SCHULZ, M.D. SUITE 240  BY THE WILL SUITE  SUITE SUITE  SUIT							195		
							Drive 21112		
	JUN 2 2 1995	32. REGISTRAR'S SIGN						-111/2	

Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760

and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit a burial, cremation, or removal. 5 the attending physician a Mental Hygiene prior to been signed by the has be Dept. OR ATTENDING PHYSICIAN: The law

95 18861 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 02:40 Pm repe JUNE 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIR 25 (Month, Day, 25 MARCH 27) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 5049 213-09-DAYS HOURS MARYLAND 1 - M 2 X F 86 YRS. permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYT, AND N/A BALTIMORE 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3601 FORDS LANE, APT. 818 21215 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married 1 TES 2 NO BY Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11 PROPRIETOR GROCERY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme notified at DAVID SHOMER HINKA Henka BE KARLOFF 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (\* Court or or Rural Route Number, City or Town, State, Zip Code) 2 JANET KRAMER 6804 HUNT DRIVE BALTIMORE De de 20a. METHOD OF DISPOSITION
1 DBurial 2 Cremation 3 Ram 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must cemetery, crematory or other piece) 4 Donation 5 Other (Specify) HEBREW FRIENDSHIP 6-20-1995 BALTIMORE, MD medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. hou Work 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, Approximate ahock, or heart fellure. List only one cause on each line interval Batween IMMEDIATE CAUSE (Fine) **Onset and Death** the Hemorrhage disease or condition ONE DAY subarachinoid resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 TYES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT marked, 26d, DESCRIBE HOW INJURY OCCURED this c 1 YES 2 NO After the BY 28e. PLACE OF INJURY — AI home, Jarm, atreet, Jactory, office building, atc. (Specify) 3 Suicide 46 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) DIRECTOR: A COMPLETED 6 Could not be 28 4 Homicide Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 NO THE FUNERAL DE THE FILE PORTANT; If IN (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29d. DATE SIGNED (Month, Day, Year) BE Medical DUNE 18, 1995

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30. NAME AND ADDE

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RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAL'S SIGNATURE

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DIRECTOR permit. FUNERAL **bunal-transit** Page 6 may be retained by the hospital or attending physician. BY funeral director, page 5 should be detached for use as the COMPLETED once. Ħ BE notified 2 pe must medical examiner after death. and completely filled in by the obunial, cremation, or removal. the event, 1 traumatic CERTIFICATION 2 physician prior other the attending phy I Mental Hygiene 10 Injury, MEDICAL signed by the any Shows a been ō has by Dept. PHYSICIAN: 23 item certificate h 0 this c marked, В After 28 is after COMPLETED DIRECTOR: / tem 80 FUNERAL C within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 BE 0 31. DATE FILED (Month, Day, Year)

Item11,20b,c,Film724,6/22/95,1t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Migdle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Bowles-Tazewe ildrea 1331 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN 1 M 2 XF Ma YRS. 01-05-BAL 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 130 W SEC TIMORA DOIRC n/a RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 19c. CITY TOWN OR LOCATION 10d. INSIDE CITY MD n/a Baltimore 1 TYPES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 501 Dolphin St. 21217 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES ZX NO Specify Specify 3 Widowed 4 Divorced Black 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12th House Wife Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roy Burnett Ada 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 CArolyn Lee Lafavette Ave. BAlto., MD 21216 20a. METHOD OF DISPOSITION

XIX Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Stafforest Dwings Mills 4 Donation 5 Other (Specify) 6/26 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JAmes A. Morton & Sons Funeral Home 202 LAurens St. BAlto., MD 21217 23. PART | Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line Interval Batween IMMEDIATE CAUSE (Finsi Onset and Dasth lyocardial Infarction disesse or condition Cute 140 C
DUE TO (OR AS A CONSEQUENCE OF) 1 hour resulting in desth) Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If sny, lesding to immediate CRUSE Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only or **EXAMINER?** HOSPITAL: OTHER:
4 \( \text{Nursing Home} \) 5 \( \text{Rasidence} \) 8 \( \text{Other (Specify)} \) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO 2 Accident Investigation 28s. PLACE OF INJURY -- At home, farm, street, factory, offica 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 29a. CERTIFIER TO CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SUGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 031064 Dune 20, 1995 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH TO 2000 W, Baltimore St Baltimore MD Fit zgerald

32. PEGISTRAR'S SIGNATURE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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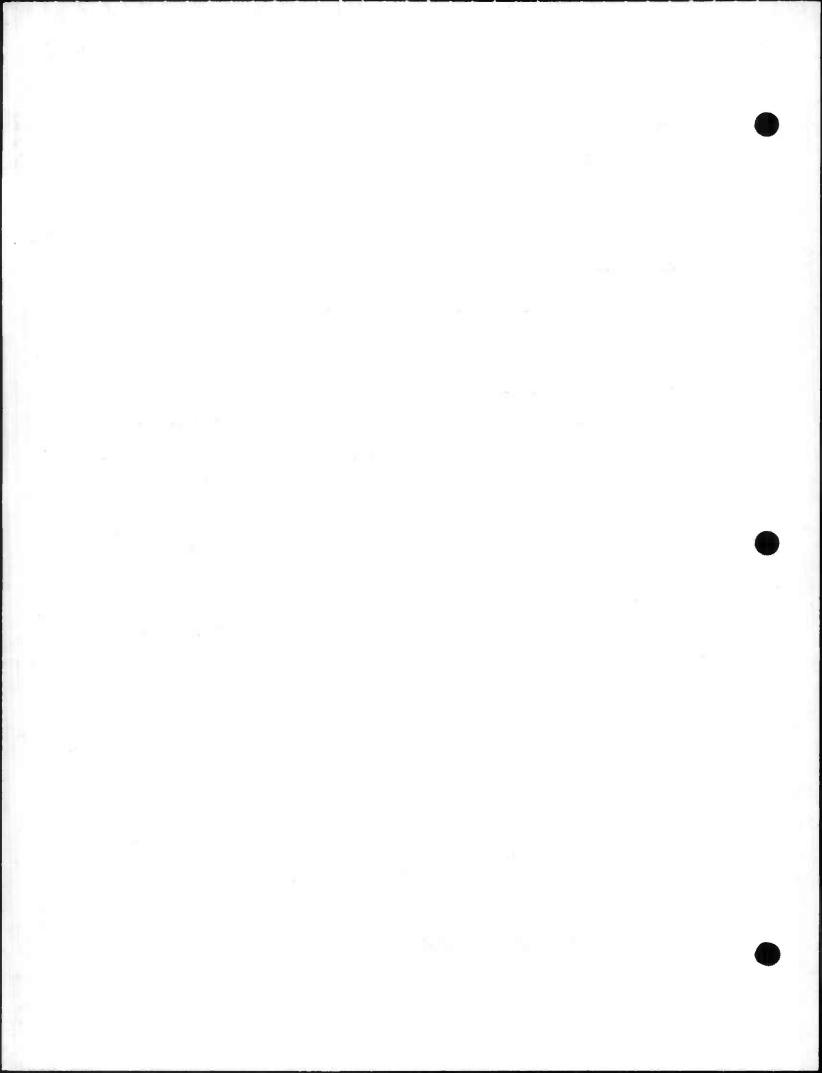
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	1 - FOR STATE REGISTRAR	STATE OF MARY	/LAND / CE	DEPARTME RTIFICA	NT OF I	HEALTH AND		GIENE i. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA	TH	2	. TIME OF DEATH	-
	George La	wrence		Tavlo	r		June	16, 19	995	9:30 A	M
			E (In yrs. last		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ye	'H	8. BIRTHPL	ACE (State or Foreign	
	226-07-5617  9a. FACILITY NAME (If not institution, give street	M2 F	82	YRS. MONTH		HOURS MIN.	Aug 16,	1912		rginia	
DIRECTOR	2525 Madison Avenu	,		9b. C		or location of D timore	EATH	1	nty of dea n/a	тн	
REC	10a. STATE 10b. COUNTY			10c. CITY, TOW	N OR LOCA	TION	· · · · · · · · · · · · · · · · · · ·		1	0d. INSIDE CITY LIMITS?	-
	Maryland 100. STREET AND NUMBER	n/a		Balt	imor					X YES 2 □ NO	
FUNERAL					10	f. ZIP CODE		10g. CITI		AT COUNTRY?	
JNE	2525 Madison Avenu		D IN II C ADA	150		21217			USA		_
	1 Never Married 2 Married	P. WAS DECEDENT EVER FORCES? 1 X YE IF YES, GIVE WAR OR	S 2 N	0	If yes, sp	CENDENT OF HISPAI Healfy Cuban, Mexica	an, Puerto Rican, et	fy Yes or No—	Black, \	- American Indian, White, etc.	
ВУ	3 🕅 Widowed 4 🗆 Divorced	ug '43 - 1	Mar '4	6	1 L YES	2 📉 NO Specif	ly:		Specify:	Black	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ION appleted)	16a. DEC	EDENT'S USUAL	OCCUPATION OF COLUMN	ON ost of working	16b, KIND O	F BUSINESS/IND	USTRY		_
Ë		College (1-4 or 5+)	illo.	Do NOT use retired	f.)						
ME	12th Grade 17. FATHER'S NAME (First, Middle, Last)			Foreman	1				Lting	& Refinar	. У
	William Calhoun Ta	vlor					ME (First, Middle, M Mitchell.	laiden Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	7 1.01	19b.	MAILINO ADDRE	SS (Street	and Number or Rural		ry Town State 7in	Code		_
2	Irene P. Montaque					ol Avenue				land 21229	9
	20a METHOD OF DISPOSITION 1	from State	Ob. PLACE A	ND DATE OF DISP	OSITION /N			c. LOCATION —			_
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENS	7	rbutu	s Memor	ial 1	Park	1 23 F	Baltimor	ce Coi	inty, MD	
	A . J	/ .		2	2. NAME A	Gwynns F:	alls Par	r Funer	al Ho	mes, Inc	
_	(June)	luis		I	Balti	Gwynns Fa more, Ma:	ryland	21216			
	23. PART I. Enter the diseases, or com shock, or heart failure. Liet	plications that ceus only one cause on	ed the dea esch line.	th. Do not ent	er the mo	de of dylng, suc	h as cardiac or	respiratory arr	est,	Approximate interval Between	1
- 1	iMMEDIATE CAUSE (Final disease or condition							_		Onset and Death	
	resulting in death) s,_	DUE TO (OR AS		MATY	47	tery	disea	26			_
z			124		1180	nzer					
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSECU	JENCE OF):						1	-
S	CAUSE (Disease or injury			nic p	mer	n19					
E	that initiated events resulting in death) LAST	DUE TO (OR AS			-1	1100 - 1					
B	d					Vascu		uden-	<u> </u>		4
	PART II. Other significant conditions of	ontributing to death	but not re	sulting in the	underlyin	g cause given in		AS AN AUTOPSY		ERE AUTOPSY FINDINGS MILABLE PRIOR TO	
Ö	, , , , , ,	ertensia						ES 2 NO	CC	OMPLETION OF CAUSE F DEATH?	
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AN	DID TOBACCO USE CONTRIB  25. WAS CASE REFERRED TO MEDICAL	UIE IO CAUSE		OF DEATH (Chec		UNCERTAIN	и Ц				4
PHYSICIAN: MEDICAL		OSPITAL:		ОТН	ER:	e 5 Masidence					-
¥	27. MANNER OF DEATH	26a. DATE OF INJUR	γ	28b. TIME OF	28c. INJ	URY AT	28d. DESCRIBE H		CUREO		-
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year	' <u> </u>	INJURY M		RK? (ES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF INJUI building, atc. (Sp	RY — At hom	e, farm, street, fe	ctory, offic		261. LOCATION (S City or Town,		or Rural Rout	le Number,	1
ETE	4 Homicide determined						- ,	,			
COMPLETED	29a. CERTIFIER (Check only one)										
00	2 MEUCAL EXAMINER: 0	n the basis of exeminat	ion and/or in	vestigation, in my	opinion, d	eath occured at the	time, data and place	ca, and due to the	n ceuse(s) ar	nd manner as stated.	
B	296. SIGNATURE AND TITLE OF CERTIFIER	BAL A.	va 4	2000	101.	29c. LICENSE NUM		29d. DATE	SIONED (M	onth, Day, Year)	
0		MENON	uding bypsician 030					30115   6/20			

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

() his KPE hai, mo 2600 liberty HOTS AVE. Balt. mo 21215 31. DATE FILED (Month, Day, Year)

JUN 2 2 1995

JUN 2 2 1995



FOR

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STATE REGISTRAR

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JUNE 1995 20 MICHAEL. TAYLOR 10:00 Am 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1956 8. BIRTNPLACE (State or Foreign 7. DATE OF BIRTH DAYS HOURS 15 M 2 | F 39 JAN. 216-66-3121 TX M 2 U

9e. FACILITY NAME (If not institution, give street and number) 8,195 MARYLAND Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1413 E.PRESTON STREET BALTIMORE N/A CITY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND N/A BALIIMORE CITY TY YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER Preston tor, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? be detached for use as the burial-transit 1413 E. PR#ESTON ST. 21213 U.S.A. attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 Never Married 2 Married

3 Wildowed 4 Divorced FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BY Specify: BLACK COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) hospital or /Secondary (0-12) College (1-4 or 5 +) 7TH HANDYMAN N/A SELF EMPLOYED once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) retained by the ALFRED TAYLOR 16 MARIE GILLIAM BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ALFRED TAYLOR E. PRESTON ST. BALTO, MD. 21213 2 Pe Раде 6 тау 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Burial 2 Cremation 3 Removal from State BALTO. JUNE 27 BALTO, MD. 1995 examiner 21. SIGNATURE OF FUNERAL SERVICE LICES 22. NAME AND ADDRESS OF FACILITY hours after death. CALVIN B. SCRUGGS FUNERAL HOME n by the f 1412 E PRESTON ST BALTO MD 21 medical filled in by t 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line 6 completely filled rial, cremation, o IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition NARCOTIC INTOXICATION event. resulting in death) P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) paccuted n and com to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a ental Hygiene prior to if any, leading to immediate the death certificate be Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the atter DIVISION OF VITAL RECORDS, Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS MARLABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Health and N that any 1 YES 2 NO requires DF DEATH? Shows 1 TYES 2 T NO been of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item Tem certificate 1 HOSPITAL OTHER: 17 YES 2 | NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5X Masidence 8 ☐ Other (Specify) the 6 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) OUND 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED this with 1 Netural JUNE 20, 1995 UNKNOWN M UNKNOWN BY After death 2 Accident 28e. PLACE OF INJURY — At home, term, street, lectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
1413 E. PRESTON ST. BALTO., ND. 3 Suicide 69 DIRECTOR: A hours after ditem 28 is COMPLETED 8)(3) Could not be 4 Homicide HOME hours Item 29a. CERTIFIER 1 \_ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE BE filed within 72 ho HOSPITAL 2 🔀 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. BE ▶ JUNE 21,1995 O.C.M.E. 9 US OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) MARypnino 111 Penn Street, Baltimore, Maryland 21201 KOREL 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

PATEL

32 REGISTRAR'S SIGNATURE

2600

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SUDHIR

31. DATE FILED (Month, Dey, Year) JUN 2 2 1995

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	0
_	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 m
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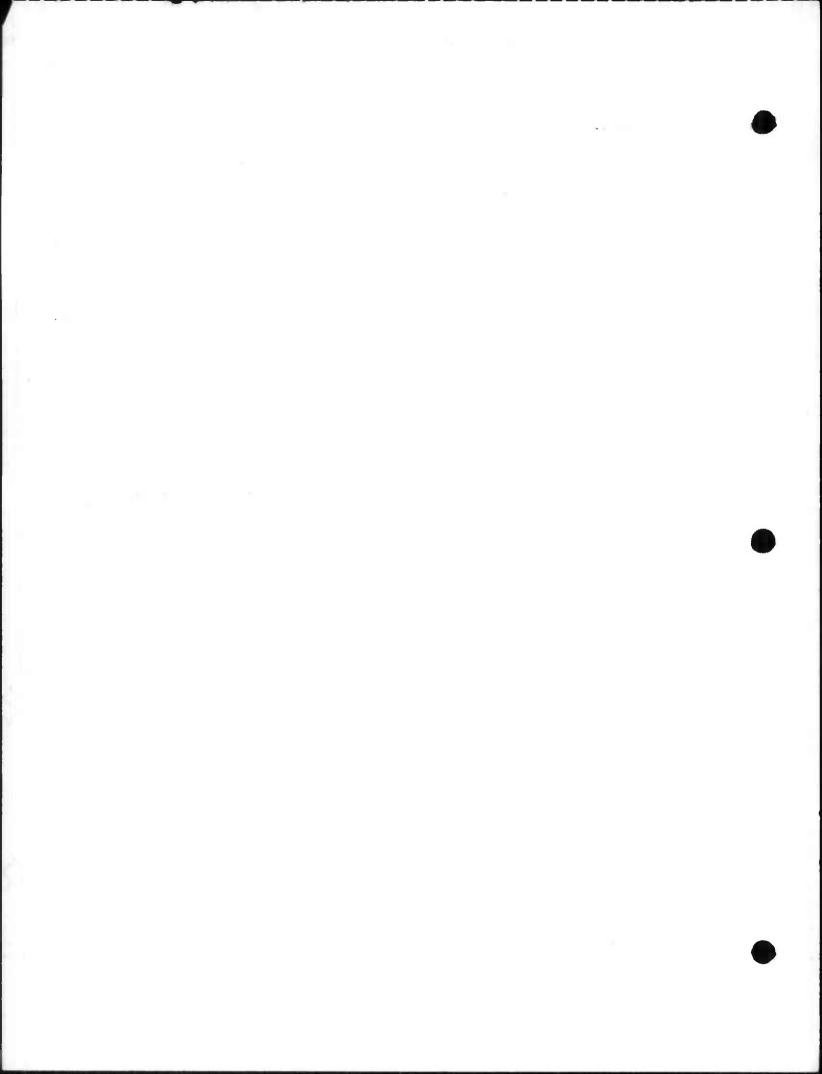
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exhibitar death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										95	5	8865
	FOR 1 - STATE REGISTRAR	STATE OF N			RTMENT (				ENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					,			2. DATE OF DEATH			3. TIME OF DEATH
	SAMOUIT	Samuel	J	CHI	ERNI	N			TUNE 1	7 14	995	8:25Pm
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 Y	YEAR II	F UNDER 2	24 HRS.	7. DATE OF BIRTH		A BIRTHE	A ACE (State or Foreign
	212-31-4076	1 Ø M 2 □ F	77	YRS.	MONTHS C	DAYS H	OURS	MINI.	OCT. 15,1	917	RUSS	SIA
	9e. FACILITY NAME (If not institution, give a	street and number)			96. CITY, T	OWN OR I	LOCATIO	N OF DEA				
OR	LIBERTY MEDICAL C	CENTER			BALTIMORE N/A							
5	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT											
DIRECTOR					Y, TOWN OR		N					10d. INSIDE CITY LIMITS?
	MARYLAND NO. STREET AND NUMBER	I/A		BA	LTIMO							1 XVES 2 NO
FUNERAL						10f, ZI	P CODE			10g. CIT		HAT COUNTRY?
N	3601 FORDS LANE, A						1215			RUS		
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	T EVER IN U.S. ARM YES 2 NOWAR OR DATES	MED	II y	res, specif	y Cuben,	Maxican, Specify:	ORIGIN? (Specify Yea Puerto Rican, etc.)	or No-	14. RACE Black, Specify	— American Indian, White, atc.	
	15. DECEDENT'S EDU	I CATION	44- 850									WHITE
COMPLETED	(Specify only highest grade	(Gh	ve kind of	work done duri se retired.)	ing most o	of working	7	16b. KIND OF BUS	INESS/INI	DUSTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 a	•)		TORY	MORK	EB			TNI	DUSTR	ΓΔΤ.
OM	17. FATHER'S NAME (First, Middle, Last)			IAC	TONI			FR'S NAME	E (First, Middle, Maiden :		)ODIN.	LAU
EC	ABRAHAM	CHERNIN					ANNA		,	JNKNOV	MIN	
00	19a. INFORMANT'S NAME (Type/Print)			. MAILING	ADDRESS (S	Street and I			ute Number, City or Town			
2	MRS. ESTHER TCHERNINA 3601 FORDS LANE, APT. 617 BALTIMORE, MD 21215											
	2Qs. METHOD OF DISPOSITION 1 OBurlei 2 Cremation 3 Removal from/State 20b. PLACE AND DATE OF DISPOSITION (Name of complexy graphics place)											
	4 Donation Donation 3 Ram	oval Irom/State	cemetery, crem	ZUK	AMUNO	-AR	LIN	GTON-	6-21-1995	BAI	TIMO	RE, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSES  22. NAME AND ADDRESS OF FACILITY  SOL LEVINSON & BROS., INC.											
	Denhous L	1										
- 1	6010 REISTERSTOWN ROAD BALTIMORE,  23 PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	shock, or heart faffure. List only one ceuse on each line.											Interval Between
	iMMEDIATE CAUSE (Final disease or condition	0-10		2								Onset and Desth
	disease or condition resulting in deeth)  a. PNUEMONIA  BUT TO (OR AS A CONSEQUENCE OF):											
_	Sequentially liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury  DISTORAGE ACONSEQUENCE OF)  ARTIERIOSCLEROTIZ HEART DISTRASE  OUT TO GRASE A CONSEQUENCE OF)											
0	Sequentisity list conditions, if sny, lesding to immediate	DUE-TO	(OR AS A CONSEQ	UENCE O	P <sub>i</sub>				•			
SA	csuse. Enter UNDERLYING	ARTE	RIOSCL	ER	2'10	HE	AP	7	DISTAS	B		
ERTIFICATION	that initisted events	DUE TO	(OR AS A CONSEQ	UENCE O	F):							
E	resulting in desth) LAST	d										
0	PART ii. Other significant condition	as contributing to	death but not re	euiting	In the unde	rivina c	ause ol	ven in D	art I. 24a. WAS AN	ALITODOV	T nut 1	USDS AUTOROUS STREET
PHYSICIAN: MEDICAL	COAGULO	PATHY	with	20	EPI	STA	ト X ) _	٤.	PERFOR	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
×									-,,		1	I TES 2 NO
Z	DID TOBACCO USE CONT	RIBUTE TO CA					UNCE	RTAIN	128.			
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check only	y one)						
ΥS	1 TYES 2 NO		ER/Outpetlant 3				_	Idenca 6	Other (Specify)			
	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF (Month, D.		26b. TIM INJ	URY	WORK?	?		ed. DESCRIBE NOW IN	JURY OC	CURED	
Β¥	2 Accident Investigation	22 21 12 2				1 YES	2 🗌					
	3 Suicide 8 Could not be 4 Homicide detarmined	building,	F INJURY — At hon atc. (Specify)	ne, larm, :	street, lactory	, offica		2	281. LOCATION (Street a: City or Town, State)	nd Number	r or Rural Ro	ute Number,
COMPLETED	20a CERTIFIER A.			_								
MP	(Check only								the cause(s) and man			
00	2 MEDICAL EXAMINE		temination and/or in	rvestigatio	on, in my opin	nion, death	n occure	d at the tin	me, data and place, and	dua lo ti	he cause(a)	and manner as stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIED	SIA	10dy	, M.	D.	29	-	SE NUMBI	300	29d, DAT	E SIGNED	Month, Day, Year) 1 1-4, 4-95
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITEM	1 27) (Type,	Print) / 2	12 4~	-11	10	12.11	/	10	7/ (-)

dibut Rd. Bollo up.

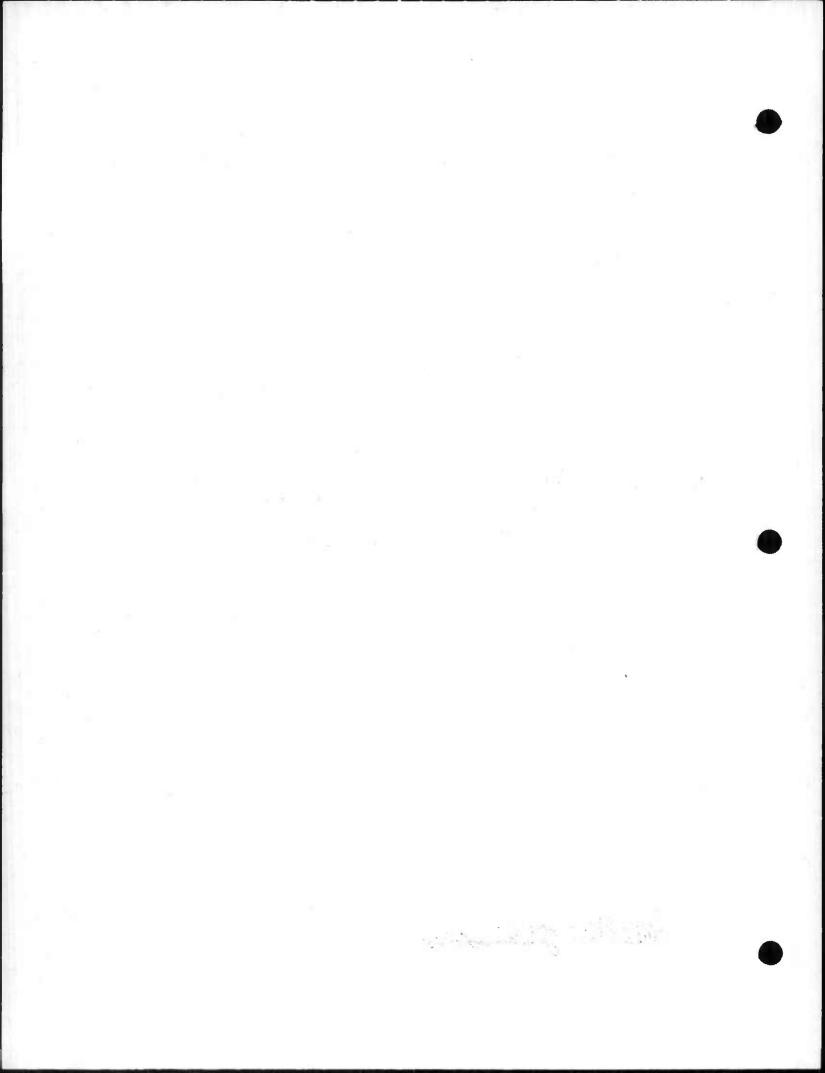


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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									18866				
	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF HEA		NTAL HYGI							
	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3.	TIME OF DEATH				
	Ralph	Valentine,	Sr.		1	MONTH	19 19	995	10:05 A M				
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)			DATE OF BIRTH		S. BIRTHPL	ACE (State or Foreign				
	404-20-4257		70 YRS.	MONTHS DAYS HO	UNS MIN.	EC. 10,		(Country)	tucky				
_	9a. FACILITY NAME (If not institution, give	street end number)		96. CITY, TOWN DR LO				ITY OF DEAT					
P	1158 Ward St.			Baltimo	ore		N,	/a					
S S	10a. STATE 10b. COUNT	Υ	10c, CITY	, TOWN OR LOCATION				1 10	d. INSIDE CITY				
DIRECTOR	Md.	N/a		altimore					LIMITS?				
AL	10e. STREET AND NUMBER			101, ZIP	CODE			AT COUNTRY?					
FUNERAL	1158 Ward St.			21	1230			USA					
15	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED		ENT OF HISPANIC			14. RACE -	American Indian, Vhite, atc.				
BY	1 Never Married 2 Narried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR	1 TES 2	Cuban, Mexican, P NO Specify:	uarto Mican, etc.	100	Specify:						
ED E	15. DECEDENT'S EQU	ICATION	150 DECEDENT'S	USUAL OCCUPATION		Last Kinio on	BUSINESS/IND		white				
	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of w life. Do NOT us	rork done during most of retired.)	working	IOD. KIND OF	BUSINESS/IND	USTRY					
ם	12	N/a	Tru	ck Driver		Trans	portat:	ion					
COMPLET	17. FATHER'S NAME (First, Middle, Last)				MOTHER'S NAME			2011					
BE (	James F. Valent:	ine		(	Georgia	Jarrel	1						
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and N				Code)					
-	Lucy M. Valentir	ne	1158	Ward St.,	Balto.	, Md.	21230						
	20e. METHOD OF DISPOSITION 1 Surface 2 Cremetion 2 Rem 4 Donation 8 Differ Specify	yoval from State Co	metery, cremetory or of	F DISPOSITION (Name of the place)				- City or Town, State					
	21. SIGNATURE OF FUNERAL SERVICE L		Mt. Zion	Cemetery	ODRESS OF FACILI	6/ <sub>22</sub> L	ansdow	ne, Mo	d				
	De /20///	7	DUNESS OF FACILI	IT			lk., Inc.						
	1 1 7 0		n St	Flkrida	e Md	2121	27						
	23. PART I. Enter the diseases, of shock, or heart failure.	complications that cause List only one ceuse on	ed the death. Do n	ot enter the mode of	of dying, such a	a cardiac or re	apiratory arm	eat,	Approximate Interval Between				
	IMMEDIATE CAUSE (Final disease or condition												
	disease or condition resulting in death)  DUE TO (OF AS A CONSEQUENCE OF):												
-	- COPD												
0	Sequentially list conditions, If any, leading to immediate												
S	cause. Enter UNDERLYING	c CH	7										
ERTIFICATION	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):												
	resulting in deeth) LAST	d											
, L	PART II. Other algnificent condition	ne contributing to deeth	but not reaulting is	n the underlying car	use given in Par	t I. 24a. WAS	AN AUTOPSY		ERE AUTOPSY FINDINGS				
2	DM					PER	FORMED?	CC	MILABLE PRIOR TO MPLETION OF CAUSE				
W									DEATH?				
z	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S   NO   L	JNCERTAIN								
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE DF DEAT	H (Check only one) OTHER:									
YSI	1 TYES 2 12 NO	1 - Inpatient 2 - ER/Ou		4 - Nursing Home 8		Other (Specify)							
	27. MANNEP OF DEATH  1 Netural 5 Pending	(Month, Day, Year)	28b. TIME INJU	JRY WORK?		d. OEȘCRIBE HO	W INJURY OCC	URED					
B	2 Accident Investigation	28e. PLACE OF INJUR	W At home to a	M 1 YES	_								
		building, etc. (Sp.	ecify)	reet, factory, office	28	f. LOCATION (Stre City or Town, St	et and Number ( ate)	or Rural Rout	e Number,				
	3 Suicide 8 Could not be determined	4 Homicide detarmined											
	4 Homicide detarmined			(Check only 1 CERTIFYING PHYSICIAN: to the best of my knowledge, death occurred at the time, date and placa, and due to the cause(e) and menner as attated.									
	4 Homicide detarmined  29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my kno											
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my knores. On the beste of examinati		, In my opinion, death	occured at the time	, data and place	and due to the	cause(s) ar					
BE COMPLETED	4 Homicide detarmined  29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my knores. On the beste of examinati		, In my opinion, death		, data and place	and due to the	SIGNED (M	nd menner as stated.				
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER STATES	ICIAN: To the best of my knores. On the beste of examinate	on and/or investigation	n, In my opinion, death	occured at the time	, data and place	and due to the	cause(s) ar					
BE COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my knores. On the beste of examinate	en and/or investigation	n, In my opinion, death	LICENSE NUMBER D262	e, data and place	29d. DATE	SIGNED (M					
BE COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER STATES	ICIAN: To the best of my knores. On the beste of examinate	EATH (ITEM 27) (Type,	n, in my opinion, death 29c	LICENSE NUMBER D262	e, data and place	29d. DATE	SIGNED (M	onth, Day, Year)				

DHMH-16 Rev 1/89



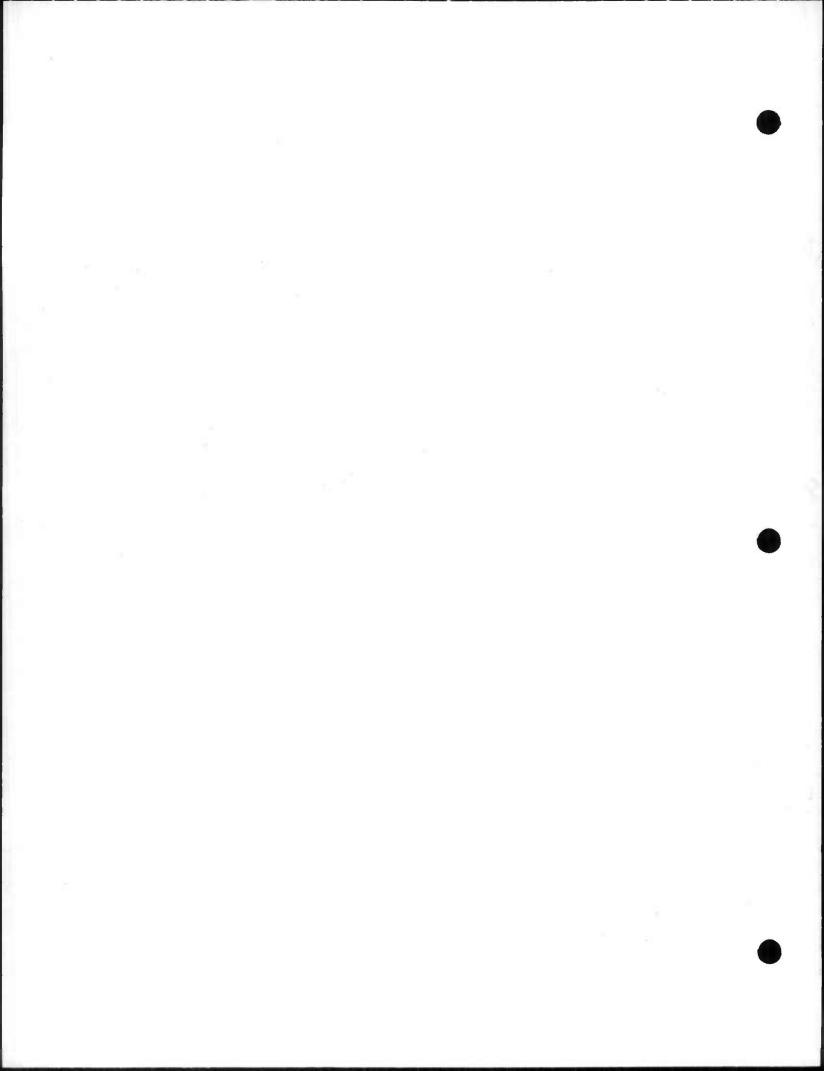
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND N	MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN					
	MARTIN	PHILIP	VEI	NZE		JUNE 19,	1995 YEAR	10:30AM M					
			Bac Bac	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)							
	221 20 2000		74 YRS.			NOV. 7,19		MARYLAND					
œ	9a. FACILITY NAME (If not institution, give stre		•		R LOCATION OF DE	ATN	9c. COUNTY OF						
DIRECTOR	MERIDIAN LONG GRE	EN		TOWSO	N		BALT	IMORE					
RE	10e. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT	ION			10d. INSIDE CITY					
		ALTIMORE		BALT	IMORE			1 YES 2 NO					
RAL	10e. STREET ANO NUMBER			101	ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?					
FUNERAL	2431 LIGHTFOOT DR				21209		USA						
	1 Never Married 2 Married	12. WAS DECEGENT EVER I FORCES? 1 YES	2 NO	If yes, spi	city Cuban, Maxican	IC ORIGIN? (Specify Yes i, Puerto Rican, etc.)	or No — 14. RA Blo	ICE — American Indian, ack, White, atc.					
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 🗆 YES	2 NO Specify.	:	Sp	WHITE					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or		16a. DECEDENT'S US	UAL OCCUPATION done during mo	N M and userables	16b. KIND OF BUS	SINESS/INDUSTRY						
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)	d or working								
MP	12		OWNER	2				RY STORE					
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	ME (First, Middle, Meiden	Sumame)						
BE	HARRY	V	ENZE		LILL			UNKNOWN					
2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	MRS_EDTTH VENZE 2431 LTGHTFOOT DRIVE BALTTMORE, MD 21209  209, METHOD OF DISPOSITION  200. PLACE AND DATE OF DISPOSITION (Name of OATE 200. LOCATION — City of Town, State												
	1 🐼 Burial 2 🗆 Cremation 3 🗆 Remov	rel from State Cer	OHEB"SHATC	M° MEMO	RIAL PARE	K - 6-21-1	995 REIS	STERSTOWN, MD					
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE /)		22. NAME AN	D ADORESS OF FAC	HITY							
	SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE												
	23. PART I. Enter the diseases, or co			6010	REISTERS	STOWN ROAD	BALTIM						
	snock, or neart failure. Li	ist only one cause on e	ech line.	onter the mo	to or dynig, such	as cardiec or reapi	ratory arrest,	Approximata Interval Between					
	AMEDIATE CAUSE (Final Issesse or condition												
	disease or condition resulting in death)  a. Acute inspectable asfauter mun.												
z													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	Immediate DUE TO (OR AS A CONSEQUENCE OF):											
5	CAUSE (Disease or Injury	DISC 70 (00 40											
Ë	thet initiated eventa resulting in death) LAST	DOE TO (OH AS A	A CONSEQUENCE OF):					1					
SE	<b>L</b> d.												
SAL	PART II. Other algnificant conditions	A .	A		ceuse given in F	Part I. 24a. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
	- northeast	puesue	kydia	cepha.	lus-	1 YES 2		COMPLETION OF CAUSE OF DEATH?					
MEDI	Cerebrovas		accel	ext				1 YES 2 NO					
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE C	F DEATH YES	□ NO □	UNCERTAIN								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATN	Check only one)									
ΙΥS	1 YES 2 NO	1 Inputient 2 ER/Out	patient 3 DOA 4	Nursing Nome	5 - Realdence (	B ☐ Other (Specify)							
- 4	1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOI	RK?	28d. DESCRIBE HOW II	NJURY OCCURED						
BY	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY	— At home, farm, stre-		ES 2 NO	284 LOCATION (0)	- 111 - 1 - 2	10 10 10 10					
	4 Homicide 8 Could not be determined	building, etc. (Spec	cify)	st, factory, office		28f. LOCATION (Street a City or Town, State)	ind Number or Hure	If Houte Number,					
	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the heat of my know	dadas dank assista										
COMPLETED		AN: To the best of my know On the basis of examination						Make as seems board					
8	290. SIGNATURE AND STILE OF CENTIFIER	A		T									
H	(Blues/	Lano	hon		29s. LICENSE NUMI	2/	•	ED (Michelly, Diego West)					
임	36. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Topo of	ho	0291	4	JUN	E 20,1995					
	BRUCE ROSE	VBERG		ORK	RD.	MTHER	11115	141210002					
Î	31. DATE FILED (MONN, Day, Warr)	ST RECOUTRARY SIGN	ATURE		,	- / // /	7,000	-10/3					
- 1	IIIN 2 2 1995 (Ze)	A JANA AMERICA	J. 17										



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATH													
	FREDERICK	WALTE	RS							MON	JUNE 21, 1995			12:40 A.M
1	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DAT	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign
8	217-01-3866		1 <b>∑</b> ∑M 2 □ F	77	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Day, Year)	1918	Country	y)
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b, CIT	FEB. 22, 1918 MARY							
R	MERIDIAN HA	MMONDS	LANE N.	н.		BRO	OKL	N P	ARK			ANI	NE AF	UNDEL
DIRECTOR	RESIDENCE OF DEC													
H	10a. STATE	10b. COUNTY				c. CITY, TOWN OR LOCATION LINTHICUM							10d. INSIDE CITY LIMITS?	
	MARYLAND	ANNE	ARUNDEL		111	ATH T								1 TES 2 NO
RAI	104. STREET AND NUMBER				101. ZIP CODE									HAT COUNTRY?
FUNERAL	405 W. MAPL					2109					red s	TATES		
	11. MARITAL STATUS  1 Never Married 2 X	Married	FORCES? 1	X YES 2					OF HISPAN an, Maxica	NC ORIG	HN? (Specify Yas o Rican, atc.)	or No-	14. RACE Black	— American Indian, , Whita, atc.
B≺	3 Widowed 4 Divo		IF YES, GIVE V	AR OR OATES			1 TYES	2 XNO	Specify	y:			Speci	WHITE
0	15, DEC	EDENT'S EDUC	CATION	16a, C	ECEDENT'S	USUAL C	CCUPATIO	ON .		T 10	6b. KIND OF BU	SINESS/IN	DUSTRY	
	(Specify only Elementary/Secondary (0	highest grade	College (1-4 or 5		Give kind of fe. Do NOT u	work done	durina mo	st of worki	ing	İ				
립	10		conege (1-4 of 5		REMAN					N	IANUFAC	TURI	NG.	
COMPLETED	17, FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	ME (First	, Middle, Maiden	Sumame)		
BE C	FREDERICK W	ALTERS						LIL	LIAN	DOE	ENGES			
	19a. INFORMANT'S NAME (7	ype/Print)		1	96. MAILING	ADDRES	\$ (Street a	nd Numbe	v or Rural I	Route Nu	mber, City or Tow	n, State, Zi	p Code)	
2	MARTHA E. W	ALTERS	1								CUM, M			
	200 METHOD OF DISPOSIT	ION			E AND DATE			me of		0/	TE 20c. LO	CATION -	City or To	wn, Slata
	1X Buriel 2 (1) Crematio 4 (1) Donation 5 (1) Other		over from State	GLEN	remetory or of HAVEI	ther place, V MEN	1. PI	(. J	UNE 2	24,	95 GLE	N BU	RNIE,	MARYLAND
1	21. SIGNATURE DE FUNGRA	- ()		22.	NAME AP	O ADDRE	SS OF FA	CILITY						
	D / 123		- 1					UNERAL			E, MD21061			
$\neg$	23. PART I. Enter the di	seeses, or c	omplications the	t caused the c	leath. Do	not ente	the mo	de of dy	ing suc	h ee ce	ording or read		DOKNI	Approximata
	ehock, or he	eart failure.	List only one cau	ise on each lir	10.			,			i diad of teap	i aloty at	Tool,	Interval Batween
	IMMEDIATE CAUSE (Finel disease or condition Carcinoma of Colon													
	DUE TO (OR AS A CONSEQUENCE OF):													
,	Liver Metastasis													
ō l	Sequentially list conditions,													
CERTIFICATION	cause. Enter UNDERLYING													
Ĕ	CAUSE (Disease or Inju that initiated events		DUE TO	(OR AS A CONS	EOUENCE O	F):	COLC							
H	resulting in death) LAST													
	PART II. Other elgoifica	nt condition	a contribution to	death but not	re evilties	Im Abo	n elevel i de c		alice to	Deat 1	T		1	
MEDICAL	The state of the s	the outlantion	e contributing to	death out not	resulting	resulting in the underlying cause given in Po				Part I.	Part I. 24a. WAS AN AUTOPSY PERFORMED?		240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ā											1 TES 2	X NO		OF DEATH?
			-											1 NES 2 NO
AN	25. WAS CASE REFERRED TO	MEDICAL T											1	
PHYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:			OTHE	R:		DEATH (Che					
¥	1 YES 2X NO		1 Inpatient 2		3 LI DOA		28c, INJ		asidenca		her (Specify)		011000	
	1 Natural 5	Pending	(Month, D			ÜRY M	WO	RK7	¬ NO	280. 0	EŞCRIBE HOW I	NJURY OC	CUNED	
B	2 Sutate	investigation	28a, PLACE C	F INJURY — At I	ome farm	street fac			_ NO	284 1 6	CATION (Street	and Mumba	e or Dumi D	Inute Alumbus
		Could not be determined	building,	etc. (Specify)	rarrie, rarrii,		tory, orne			Ch	y or Town, State)	ina nymbe	r or nurer n	oote Namber,
COMPLETED	29a. CERTIFIER . V						_							
MP	(Check only 1.4) CERT		CIAN: To the best of											
8				xamination and/o	r investigatio	on, in my	opinion, d	eath occu	ired at the	time, da	ta and placa, an	d dua to t	he cause(a)	) and manner sa stated.
BE	296. SHANATURE AND TITLE	OF CERTAIN		MD.	•				ENSE NUN			11000		(Month, Day, Year)
2	4100	Jus of		ttendin			.an)	D1	4160	)		J	UNE 2	22, 1995
- 1	30. NAME AND ADDRESS OF						77.7.	TMOT	E	A D ***	AND OF	225		
	HARJIT SING					.,	ALT.	LMOR.	E, M	AKYI	TAND ST	225		
	31. 0 JUN 2 0 2 19	95 9	32. EGISTRA	R'S SIGNATURE	,									
- 11		0												



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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, within 72 hours after death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal.	
attending physician.	se as the burial-trans	
ed by the hospital or	uld be detached for u	ed at once.
Page 6 may be retain	director, page 5 sho	er must be notifi-
HOSPTAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	iled in by the funeral	TANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
be executed within a	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu within 72 hours after death with the State Dept. of Health and Mental Hopiene prior to burial, cremation, or removal	aumatic event, th
the death certificate	y the attending physical Mental Hydriene pri	injury, or other to
The law requires that	te has been signed b te Dept, of Health ar	em 23 shows any
NDING PHYSICIAN:	t: After this certifical	is marked, or ite
HOSPITAL DR ATTE	FUNERAL DIRECTOR within 72 hours afte	TANT: If Item 28

TO THE HOSPITAL (
TO THE FUNERAL D
De filed within 72 h
IMPORTANT: If 18

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIER

lonald &

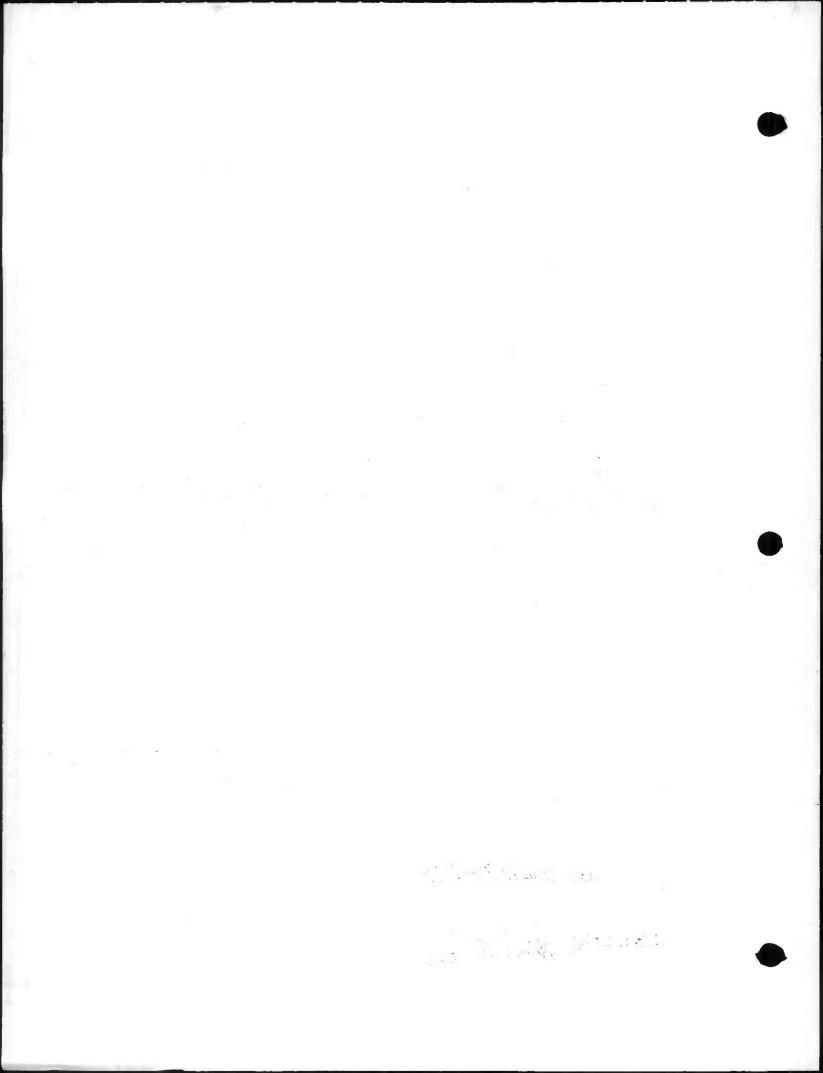
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WRIGHT

95 18869 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR DAVID J. WAHLERS 1995 JUNE 12:57 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) JAN. 8, IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN. 210-58-3929 1 X M 2 - F Scranton, 1973 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CAPRI CONDO ON 112th.STREET DIRECTOR OCEAN CITY WORCESTER RESIDENCE OF DECEDENT 10a, STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Lackawanna Scranton 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 442 Hickory St. 18505 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, stc.) BY 1 TYES 2 NO Specify: Specify: 3 Wildowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 12 N/A Check-out Clerk Food Service 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) David Wahlers M. Josephine Eble BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 David Wahlers 442 Hickory St. Scranton 18505 20a. METHOD OF DISPOSITION
1 M Burial 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Buriel 2 Cremation 1 Donation 5 Other (Specify) 6/22 Fairview Memorial Park Elmhurst, Pa 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 23. PART t. Enter the isseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition\_ ultiple injuries resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1X YES 2 | NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
1 | Inpatiant 2 | ER/Outpatient 3 | DOA 1 X YES 2 NO OTHER:
4 | Nursing Home 5 | Residence 8 Other (Specify) | SCENE OF ACCIDENT 27. MANNER OF DEATH 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 28c. INJURY AT WORK? 1 Netural 1 YES 2 NO 6/18/95 SUBJECT FELL BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 112 ST 3 Suicide COMPLETED 8 Could not be 4 Homicide HOTEL OCEAN CITY WORCESTER 29a. CERTIFIER
(Chack only

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner es stated. (Check only one) 2 \_\_\_\_MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) Wright MD JUNE 18,1995 O.C.M.E. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD 111 Penn Street, Baltimore, Maryland 21201



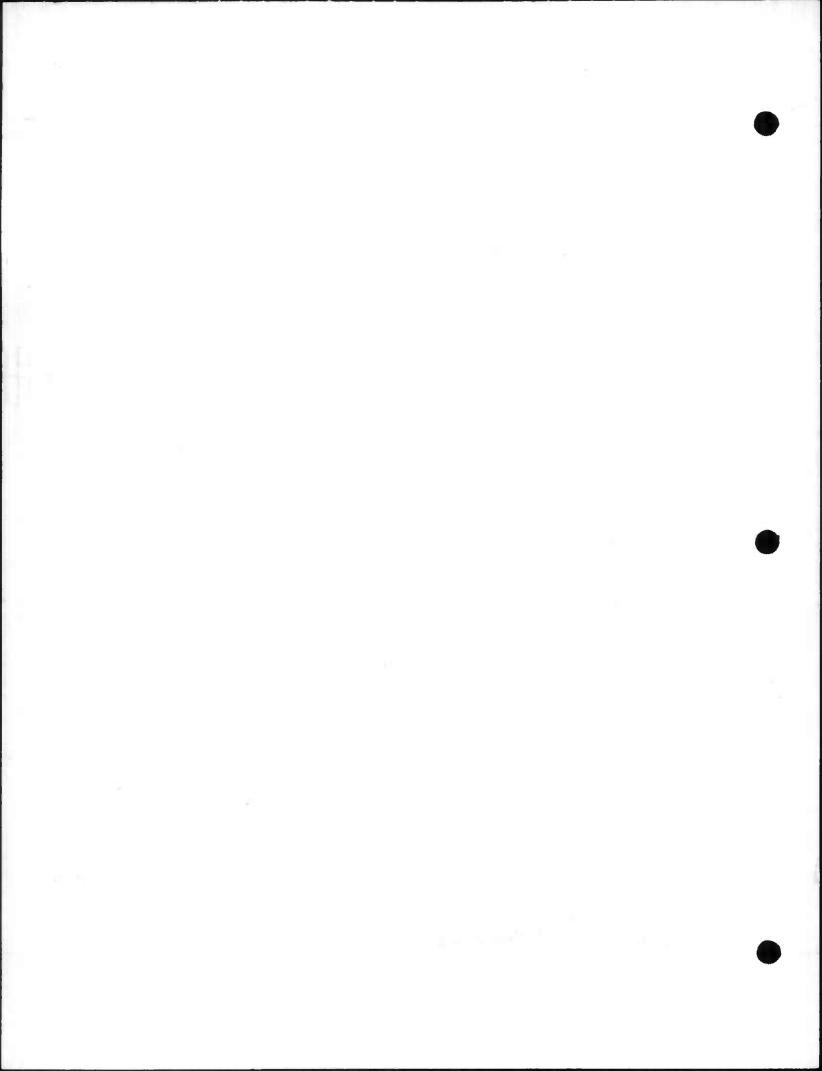
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
CERTIFICATE OF DEATH		REG NO

	FOR 1 - STATE REGISTRAR	STATE OF		DEPARTI					IENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Last)					<u> </u>	DEATH.		2. DATE OF DEATH			3. TIME OF DEAT	н
	MARY	LOU	WILLIAMS	3					JUNE 20	), 19	95	5:00	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last		F UNDER 1	_	IF UNDER 24		7. DATE OF BIRTH		6. BIRT	HPLACE (State or For	
1	219-22-4110A	1 🗌 M 2 💢 F	70	YRS.	ONTHS	DAYS	HOURS	MIN.	AUG. 31, 19	924	S.	 C AROLIN	A I
~	9e. FACILITY NAME (If not institution, give a	street and number)		9			LOCATION			9c. COU	NTY OF E		
0	4503 Hampnett Av	e.			BA	LTIN	10RE	CI	TY		n	/a	
DIRECTOR	10a. STATE 10b. COUNT			10c. CITY, 1	TOWN OR	LOCATI	ON					10d. INSIDE CITY	
뜸	MARYLAND	n/a			BA	LTIN	10RE					Y LIMITS?	NO.
AL	10e. STREET AND NUMBER				10f.			10g. CIT	ZEN OF	WHAT COUNTRY?			
FUNERAL	4503 HAMPNETT	AVENUE					21	214		UNI.	TED	STATES	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARM	IED	13. W	AS DECE	NDENT OF	HISPANIC	C ORIGIN? (Specify Ye	e or No-	14. RAC	E — American India	n,
BY	1 Never Married 2 MyMarried 3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES	,		YES		Specify:	Puerto Rican, etc.)		Spec	k, while, etc.	
	15. DECEDENT'S EDU	ICATION .	14- 000		<u> </u>		7171					DLAGK	
	(Specify only highest grade	completed)	(Ghr	EDENT'S US wind of wor Do NOT use r	k done du	ring mos	t of working		16b, KIND OF BU	JSINESS/IND	DUSTRY		
COMPLETED	Elementary/Secondary (0-12) 6 TH	College (1-4 or 5	DOMESTIC in own								ome		
õ	17. FATHER'S NAME (First, Middle, Last)					Т	16. MOTHE	R'S NAM	E (First, Middle, Maider				
BEC	HENRY ADDISO	N						IDA	REESE				
2	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING A	DORESS (	Street an	d Number or	r Rural Ro	ute Number, City or To	vn, State, Zip	Code)		
F	196. INFORMANT'S NAME (Type/Print)  JESSE J. WILLIAMS  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4503 HAMPNETT AVENUE, BALTIMORE, MD 21214												
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ram	noval from State	20b. PLACEAN	ND DATE OF	DISPOSIT	ION (Nan	ne of		DATE 20c. L	OCATION -	City or To	own, State	
	4 Donation 5 Other (Specify)		DULAN	VEY V						)WSON	, MA	RYLAND	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY												
	1 - vand	- X	ten	-	Ma	arch	F.H.	. Ea	st 1101	E. No	orth	Ave.	
	23. PART I. Enter the disesses, or shock, or haert feiture.	complications the	it caused the dee	th. Do not	enter ti	hs mod	e of dying	g, such	as cardiac or resp	iratory arr	est,	Approxima	
ı	IMMEDIATE CAUSE (Finsi	List only one car		-						31 /		Onset and	
	disease or condition resulting in death)	a	200	()e 4	(	A	2 17,	AC	DEMS	61		1611	
		DUE TO	(OR AS A CONSEOU	JENCE OF):		. ^	R	10	1 2 -16	MI		1 201	<u> </u>
S	Sequentisity list conditions, b. CONDEDUENCE OF):  ONDER AS A CONSEQUENCE											5	
Ę	oue to (or as a conscouence of):  If any, leading to immediate cause. Enter UNDERLYING											300	5
HIFICATION	CAUSE (Disease or injury thet initiated events	OUE TO (OR AS A CONSEQUENCE OF):								0			
H	resulting in death) LAST	4											
3	DARK II Oshan dariffan dan dist												
¥	PART ii. Other significant condition	ia contributing to	death but not re	eulting in	the und	erlying	cause giv	en in P	art I. 24s. WAS AP PERFO		24b	. WERE AUTOPSY FIN AVAILABLE PRIOR T	
MEDIC			INC	10		& C		J	1 □ YES	2 PNO		OF DEATH?	USE
	DID TODA COO LICE CONTE		ستربيا	/71								1 - YES 2 19-46	6
AN	DID TOBACCO USE CONT	KIBUTE TO CA		OF DEATH		0 🗹	UNCE	RTAIN					
HYSICIAN	EXAMINER?	HOSPITAL:		0	THER:								
	27. MANNER OF DEATH	28a. DATE OF	ER/Outpetlant 3	28b. TIME 0		8c. INJU		- 7	Other (Specify)  28d, DESCRIBE HOW	#1 #1 my 0.04	NIBER		_
٦	1 Netural 5 Pending	(Month, D		INJUR		WOR	K?		280, DESCRIBE HOW	INJUHY OCC	JUNEU		
R	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE C	F INJURY — At hom	e, ferm, etra	al, factor			-	261. LOCATION (Street	and Number	or Rumi I	South Number	
3	4 Homicide 6 Could not be determined	building,	atc. (Specify)						City or Town, State	)	Or Figure 1	TOUR THURSDAY	
4	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the heat of	en knowledge dest		-4 Ab - Al		and other con-	-1.1					
COMPLE									o line cause(a) and ma me, data and place, a			) and menner as at-	ted
	296. SIGNATURE AND TITLE OF CERTIFIE				, -,-	-							
N	Jim	2 Mi	mo my	,			29c. LICENS	C/C	4	29d. DATI	1	(Month, Day, Year)	1
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAU	SE OF DEATH (ITEM	27) (Type, Pri	int)		'/	20			e/	2 11. 2	>
	60	V 0-6	Wire my	16	01	100	L'ul	SUE	~ BLVD	1	10	2 mw 2	(234
	JUN 2 2 1995	32 REGISTRA	R'S SIGNATURE	- 1	- /					( (	-		$\dashv$
	JUN 2 2 1995 A	he divole	March										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

95-3606-510

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1. DECEDENT'S NAME (First, Middle, Last)  JERMAINE			W	RIGHT	MONTH	-		EAR	TIME OF DEATN
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. lest birthda	y) IF UNDER 1 YE	AR IF UNDER 24 HRS.	JUNE 7. DATE O	NE BIRTH	10		531 CE (State or Fore
	219-92-1653	1 💢 📈 2 🗆 F	19 YRS	MONTHS DA		AUG	3,19	75	MARYL	AND
	Se. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOV	MN OR LOCATION OF D		· · · · · · · · · · · · · · · · · · ·	9c. COUNTY	OF DEATN	1
DIRECTOR	2207 O'DELL AV	/E		BALT	IMORE C	ITY			n/	/a
Ä	10e. STATE 10b. COUNT	Υ	10c. 0	CITY, TOWN OR LO	DCATION				10d.	INSIDE CITY
111-		n/a		BALT						( XES 2 □ N
FUNERAL		AVENUE			101. ZIP CODE 21237			UNITE		TATES
à l	11. MARITAL STATUS  1	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OF	ES 2XXNO	II yes	DECENDENT OF NISPA I, specify Cuban, Mexic YES 2 X NO Speci	en, Puerto R		or No 14.	Black, Wh	merican Indian ite, etc. black
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Ghm kind i	T'S USUAL OCCUP of work done during	PATION a most of working	16b.	KIND OF BUS	SINESS/INDUS	TRY	
COMPLET	Elementary/Secondary (0-12) 10 TH	College (1-4 or 5+)	Ille. Do NOI	employed			n,	/a		
Š I	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, M				
₩  -	JAMES WRITI	SR. JAM	ES WRIGH	T SR.	EZE	LL	JONES			
2	194. INFORMANT'S NAME (Type/Print)  EZELL WRIGH	4T	19b. MAILI 231		eet and Number or Rural					1007
ŀ	20a. METHOD OF DISPOSITION		20b. PLACE AND DAT					ORE, MI		1237
	X Burial 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		cemetery, crematory o			6-26		NDALLS		
	21. SIGNATURE OF FUNERAL SERVICE LIC		7		E AND ADDRESS OF F		10.0	·DITELO		110
-	23. PART I. Enter the diseases, or o	complications that cause	sed the death, Do		M. C. MRC		H11(		NORT	H AVE
	IMMEDIATE CAUSE (Finel	a. GULLIAGO DUE TO (OR A	n each line.						į	Interval Be Onset and
FICATION		DUE TO (OR A	S A CONSEQUENCE	OF):						
IIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events	b. DUE TO (OR A	S A CONSEQUENCE  S A CONSEQUENCE	OF):						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. DUE TO (OR A	S A CONSEQUENCE	OF):						
	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR A:	S A CONSEQUENCE	OF):			24a. WAS AN PERFOR	MED?	COM OF D	LABLE PRIOR TO PLETION OF CA DEATH?
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificent condition	DUE TO (OR A:  DUE TO (OR A:  DUE TO (OR A:  d.  as contributing to deeth	S A CONSEQUENCE	OF): OF): g In the underi	ying cause given in		PERFOR	MED?	COM OF D	E AUTOPSY FINI LABLE PRIOR TO PLETION OF CA MEATH? YES 2 NO
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS DU	S A CONSEQUENCE  S A CONSEQUENCE  h but not resultin	OF):  OF):  g In the underl  YES NO  EATH (Check only of	ying cause given in		PERFOR	MED?	COM OF D	LABLE PRIOR TO PLETION OF CA DEATH?
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3 Suicide  a Could not be determined  4 Hemicide  Could not be determined  28e. PLACE OF INJURY — At home, farm, stree1, factory, office building, etc. (Specify)  28e. PLACE OF INJURY — At home, farm, stree1, factory, office City or Town, State)				(WORD), D	ay, rear;	IN.	M	_						
	- 10	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home building, etc. (Specify)					atreel, factor	y, office		281. LOC City	ATION (Street a or Town, State)	and Number or	Rural Rout	e Number,
	19 01		ermined	29e. CERTIFIER  Charles and the lime data and place and due to the cause(s) and macros and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) an										
one) 2 MEDICAL EXAMINER: Dn the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manning the cause (e) and manning the cause (e) and manning the cause (e) and	EIEUBY	4 Homicide dete	ING PHYSIC		(Check only 1 LO NERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.									
296. SIGNATURE AND TITLE OF CERTIFIER  29d. DATE SIGNED (Month, De	EIED BY	4 Homicide dete	ING PHYSIC							ne time, date				d manner ee sta
	E COMPLETED BY	29e. CERTIFIER (Check only one)  29 MEDICAL	ING PHYSIC						eath occured at the			d dua to the o	cause(e) er	
	) BE COMPLETED BY	4 Homicide dete	EXAMINER CERTIFIER	in the beala of a	camination and	Vor Investigation	on, In my opi		29c. LICENSE N	UMBER		d dua to the o	cause(e) er	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

WIND TIES

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	0
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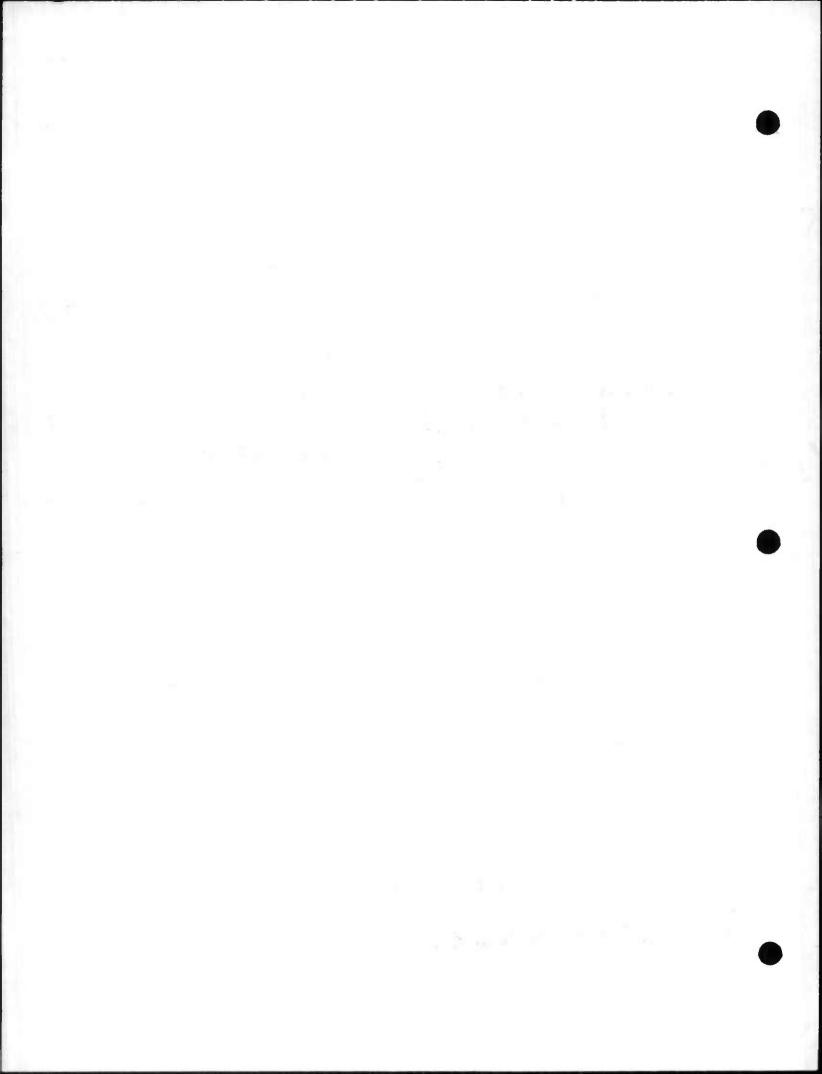
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within — hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		CE	RTIFICATE	O	F DEAT	H		REG NO

	1 - STATE REGISTRAR	STATE OF MARYLAND / DI	EPARTMENT OF HEALT	H AND MENTA	AL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	Villiams		2. DAT MON	NO 19 19	YEAR 3	TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 850-36-286		Thday) IF UNDER 1 YEAR IF UNDER 1 YEAR HOURS	DER 24 HRS. 7. DATE	E OF BIRTH Wh, Day, Year) 24	8. BIRTHPL Country)	ACE (State or Foreign					
TOR	9a. FACILITY NAME (If not institution, gived	A. Ave. Apt.	Balti	MORR		NTY OF DEA	TH					
DIRECTOR	100. STATE 10b. COUNT	N/A I	OC. CITY, TOWN OR LOCATION	ro			od. INSIDE CITY LIMITS?  YES 2 \( \text{NO} \)					
FUNERAL	100. STREET AND NUMBER 100. CITIZEN OF WHAT COUNTRY?  1100 Penna, Ave. 313 21201 USA											
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMET FORCES? 1 YES 2 PAO IF YES, GIVE WAR OR DATES		Ban, Mexicen, Puerto	IN? (Specify Yes or No— o Rican, etc.)	14. RACE — Black, V Specify:	- American Indian, White, etc.					
	16. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	e completed) (Give I	DENT'S USUAL OCCUPATION tind of work done during most of work NOT, use retired.)	rking 16	b. KIND OF BUSINESS/INC	DUSTRY	DIOCIN					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0 1	aborer 16. MC	OTHER'S NAME (First,	Const	ruc	tion					
BE	199. INFORMANT'S NAME (Type/Pript)	Illiams 196, M	AILINO ADDRESS (Street and Numl	annie	e Gra	han	n					
5	Chery W	Illiams 52	4 Allenda	e 5t. 1	Balto.M	J. 2.	1229					
	1 D'Burtel 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 8 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	novel from State codeby Courses	22. NAME AND ADD	tery 6/2	1945 Kings	Tre	e,S.C.					
	Joseph	J. Ku	りまるよう	L. Rus	& Funer	al t	MD 2/2/6					
	IMMEDIATE CAUSE (Final disease or condition	complications that caused the death List only one cause on each lina.	Prostatic			est,	Approximate interval Between Onset and Daeth					
_	resulting in death)	DUE TO (OR AS A CONSEQUE	NCE OF):	Corci	Vomel		1 oftens					
CATIO	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUE	NCE OF):									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUE)	NCE OF):									
- 1	PART II. Other algorificant condition  PART II. Other algorificant condition	na contributing to deeth but not resu	iting in the underlying ceuse	given in Part I.	24a. WAS AN AUTOPSY PERFORMED?	AM	ERE AUTOPSY FINDINGS WILABLE PRIOR TO					
PHYSICIAN: MEDICAL	ANEMIL	7			1 TYES 2 NO	OF	OMPLETION OF CAUSE F DEATH?					
CIAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE OF DEATH  26. PLACE OF	F DEATH (Check only one)	ICERTAIN								
HYSI	1 U YES 2 THE	1   Inpatient 2   ER/Outpatient 3	OTHER: 4   Nursing Home 5   b. TIME OF   28c, INJURY AT   INJURY   WORK?		er (Specify)	CURED						
B≺	1 Stetural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY — At home,	M 1 TES 2	281. LO	CATION (Street and Number	or Rural Roul	e Number,					
OMPLETED	4 Homicide determined	building, atc. (Specify)			or Town, State)							
COMP		ICIAN: To the bast of my knowledge, death of ER: On the basis of examination and/or inves					nd menner as stated.					
B	29b. SIGNATURE, AND TITLE OF CERTURE	delemon n	w 1.	ONSE NUMBER	30 29d. DAT	SIGNED (MC)	9. 1995					
2	MARVIN TEL	DMAN, MD, 301	ST. PAUL PL;	#407 -	BALTO MI	, à	1202					
	31. DATE FILED (Month, Day, Year)	32. DECHETRAR'S SIGNATURE		10/	AICIO., FIL	7.4	400					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	Item22 6	-22-95 F	ilmG724	W.H.	Per	F/H					95		8874
	FOR 1 - STATE REGISTRAR	STATE OF 1	MARYLAND C	DEPAR ERTIF	RTMEN	T OF H	EALTH DEA	AND I	MENTAL	HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)				.0711		DEA		2. DATE	OF DEATH			3. TIME OF DEATH
	SARAH	WEISS	MAN						MONTH			YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	at hirthday)	IE IIMDE	R 1 YEAR	IF UNDER	24 MD0		DE BURTH	.993	A DIOT	HPLACE (State or Foreign
	100 14 0706	1   M 2   F		YRS.	MONTHS	1	HOURS	MIN.	(Month	Day, Year)	000	Coun	try)
	188-14-8706  9a. FACILITY NAME (If not institution, give	X	71_		01: 007				NOV	. 25,1	-		ENNSYLVANIA
œ			4.7			Y, TOWN C			EATH			NTY OF	DEATN
2	THE JOHNS HOPKIN	NS HOSPIT	AL		BAL	JTIMO	RE C	ITY			N/	A	
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	ION		-				10d. INSIDE CITY
H	MARYLAND	BALTIMOR	D			DATE	IMOR	) E					LIMITS?
	10e. STREET AND NUMBER	DALITIOR	, r. i				ZIP COD				10- 017	TITEN OF	1 YES 2 NO
FUNERAL	4 500000 00000					100	, LIF COD						WHAT COUNTRY?
쀨	4 POMONA NORTH, APT 5 21208 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC								US	_			
	1 Never Married 2 Married	FORCES? 1	YES 2 2		13,	If yes, spe	ENDENT ( polify Cube	OF HISPAN In, Mexica	NIC ORIGIN'	? (Specify Yea ican, etc.)	or No—	14. RAC Blac	E — American Indian, ik, White, etc.
BY	3,Widowed 4 _ Divorced	IF YES, GIVE Y	WAR OR DATES A			1 TYES	2 X NO	Specify	y:			Spec	WHITE
	15. DECEDENT'S EDU	ICATION	16a Di	CEDENT'S	LISUAL C	VCCHBATIC	MAJ .		100	KIND OF BUS	100000000000000000000000000000000000000	Dilawan	MUTIE
ETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(G	ilve kind of . Do NOT u	work done	during mo.	st of workli	ng	100.	KIND OF BUS	IME22/IMI	DUSTRY	
7	1.2	College (1-4 or 6	+)	110110		355							1
COMPL	17. FATNER'S NAME (First, Middle, Last)			HOUS	EWIE	16	40. 1400			OWN HO			
	10. MOTHER STANKE (FIS), MINUNE, MINUN												
BE	1.FWTS DOBB SOPHIE POLITER  196. INFORMANT'S NAME (Type/Print) 195. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
임			19	b. MAILING	ADDRES	S (Street a	nd Number	or Rural F	Route Numb	er, City or Town	n, State, Zip	Code)	
	MRS FAVE NEWCON	/IR						YACK		y, 109			
	1 Deurial 2 Cremetion 3 Rem	ioval from State	20b. PLACE cemetery, cre				me of		DATE	20c. LO	CATION —	City or To	own, State
	4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE Light	2511055	BAL!	PIMOF				6-	-21-1	995 RE	ISTE	RST	WN, MD
	21. SIGNATURE OF FUNEFILE SERVICE LI	)//	1/1/1	1	22.	NAME AN	LEVI		T C B	OLO RE	EISTE	RST	OWN RD.
	Sion	411. L	UMIX	1							TNC.	BAI	TO.,MD <sub>21215</sub>
	23. PART I. Enter the dissesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,  Approximate												
	ahock, or heart feilure. Liat only one cause on each line.  IMMEDIATE CAUSE (Final										interval Between Onset and Death		
	disease or condition	Moto	state	1.	100	00	000	2					1/ 2004
	reaulting in death)	DUE TO	(OR AS A CONSE	OUENCE O	P: 3	- 4	nce	4					16 MONTHS
z		Rena	1 fail	(									4 1
TIFICATION	Sequentially list conditions, if any, leeding to immediate	Mr. T. Arch.	(OR AS A CONSE	DUENCE O	F):								10475
S	cause. Enter UNDERLYING	. Mali	onent	a 50	cite	(							18 days
Ē	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSE	DUENCE O	F):	)							100493
ERT	reaulting in death) LAST	d											
O	PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
MEDICAL	PARTIE. Other argumeant condition	e contributing to	deeth but not i	esulting	in the ur	nderlying	cause (	lven in i	Part I.	24a. WAS AN PERFOR		248	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă										1   YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?
뿔									_				1 TES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🛛	NO 🗆	UNC	ERTAIN	1 🗆				1
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	TH (Check	only one)							
PHYSICIAN:	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE!		5 🗆 Re	aldence	6 🗆 Other	(Specify)			
到	27. MANNER OF DEATH	28s. DATE OF (Month, D		28b. TIM		28c. INJU	JRY AT	Т		RIBE NOW IN	JURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(11010),	uy, 10m/		M	1 🗌 Y		NO					
	3 Suicide 8 Could not be	26e. PLACE O	F INJURY — At ho	me, ferm, s	itreet, fact	tory, office			281. LOCA	TION (Street a	nd Number	or Rural I	Route Number,
TED	4 Homicide determined	bulloning,	(openiy)						City o	Town, State)			
COMPLET	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledge de	ath occum	ed at the t	lime, date	and place	and due	to the save	e(e) and mo-	ner en el	ad.	
ž I													and menner so eleted
One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated									.,				

M6321

death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,

MS 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Mark Levis MI 31. DATE FILED (Month, Day, Year) JUN 2 2 1995 JOHNS HOKUS

12. REGISTRAPS SIGNATURE

LLi Sturdion Roydall Hospito

DHMN-16 Rev 1/89

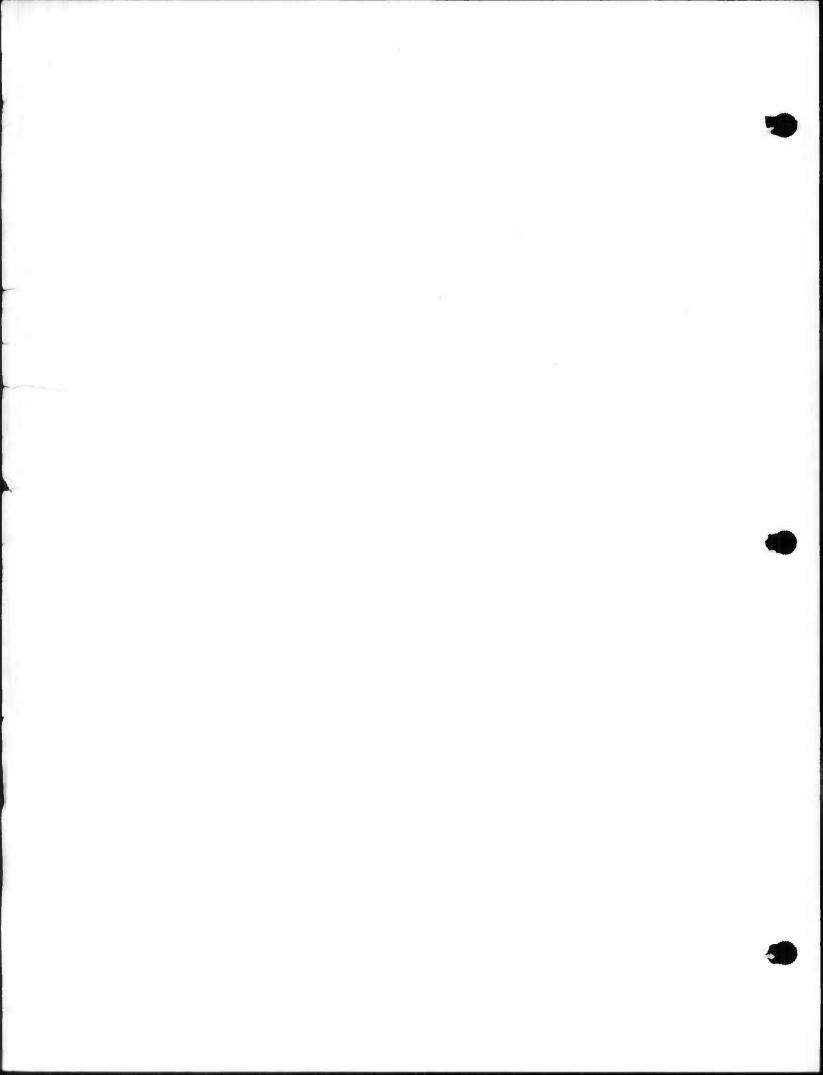
With	crem	vent
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, crem	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event
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31. DATE FILED (Morth, Day, Year)

JUN 2 2 1995

						2	10013				
	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AND	MENTAL HYG						
	1. DECEDENT'S NAME (First, Middle, Last)		OLIVIII 10	AIL OI DEATH	2. DATE OF DEAT		3. TIME OF DEATH				
	6 1		1 Anus		MONTH		303 A M				
	4. SOCIAL SECURITY NUMBER	7. OFY A 407.0-	Jouns		HEME	20 199	7				
	2/7 27 3002	5. SEX 8. AGE (In	-	MODER 1 YEAR IF UNDER 24 HRS.  MTHS DAYS HOURS MIN.	7, DATE OF BIRTH (Month, Day, Yell 12 / 1 / 6	(r)	BIRTHPLACE (State or Foreign Country)				
<u>cc</u>	9a. FACILITY NAME (If not institution, give str	pet and number)	91	D. CITY, TOWN OR LOCATION OF O	,	9c, COUNTY	OF DEATH				
은	RESIDENCE OF DECEDENT	ALDOUN -	3/	Balls , ma	7 '	180					
	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATION			10d. INSIDE CITY				
. DIRECTOR	Md	N.A.	131	ALTO!			1 X YES 2 NO				
FUNERAL	100. STREET AND NUMBER	BLLOUN S	7	21217		U,	S A				
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U		13. WAS DECENDENT OF HISPA			RACE — American Indian, Black, White, etc.				
BY F	1 Never Married 2 Married 3 M Widowed 4 Divorced	IF YES, GIVE WAR OR DATE		if yes, specify Cuben, Mexico 1 ☐ YES 2 MND Specif		,	BLACK				
ETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION (pompleted)	IGa. DECEDENT'S US (Give kind of work life. Do NOT use n	done during most of working	16b. KIND OI	BUSINESS/INDUS	TRY				
APLE	Elementary/Secandary (0-12)	College (I-4 or 5+)	House	0	/	/, A.					
coMPL	17. FATHER'S NAME (First, Middle, Last)	6	2000	18. MOTHER'S NA	AME (First, Middle, Mi	tehell					
BE a	19a. INFORMANT'S NAME (Type/Print)		19h MAII ING AC	ODRESS (Street and Number or Rural	Boute Mumber City o	Town, State, Zip Co	da)				
TO BE	FLORENCE K	idd	1350		AVE &		Md 21239				
2	200 METHOD OF DIRRORITION	20b. I	PLACE OF DISPOSITI	ON (Name of cemetery, crematory or	77.7.2	,	or Town, State				
E E	1 Burist 2 Cremation 3 Remo	wal from State	AR bUT	us Mem. F	KI	PROUTU					
iner	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	/		ACILITY		TIA				
medical examiner must	Joseph J.	Locks of	/	7.0	esal Hon		n. Central 98				
dica	23. PART/I. Enter the diseases, or c shock, or heart failure. I	omplications that cadsed t List only one cause on eac		enter the mode of dying, suc	ch as cardiac or i	reapiratory arrest	Approximate Interval Between				
Ē	IMMEDIATE CAUSE (Final						Onset and Death				
the	disease or condition	resulting in death) = a. Colon Caracter With melanases to hughla									
Vent	DUE TO (OR AS A CONSEQUENCE OF):										
2 Z	6										
ry, or other traumatic event,	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):								
E 8	cause. Enter UNDERLYING CAUSE (Disease or Injury										
E E	that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF):								
5 K	resulting in death) LAST	J									
	DADT II Other significant condition	e anatolhusina ta daeth hu	t not noutline in	the middle part of the bear to	Post I Tor- um	0.411.417770004	Last week attacks submoss				
틧룄	PART II. Other significant conditions	contributing to death but	t not resulting in	the underlying cause given in	PET I. 248. W	S AN AUTOPSY RFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
MEDICAL					1 🗆 YI	ES 2 NO	OF DEATH?				
shows any inju							1 TYES 2 NO				
23 st											
Item 2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH (C	heck only one)						
or ite	1 TES 2 NO	1   Inpatient 2   ER/Outpet		THER:    Nursing Home 5 Residence	6 Other (Specify	)					
	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (		26d. DESCRIBE H	OW INJURY OCCUP	RED				
marked, BY PH	1 Natural 5 Pending Investigation	(MOIN, Day, 10ml)	1100/1	M 1 YES 2 NO							
	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY -	- At home, farm, stre	et, factory, offica		treet and Number or	Rural Route Number,				
28 TE	4 Homicide determined	building, etc. (Specify	y) -		City or Town,	State)					
item PLE	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the heat of my knowle	doe, death occurred	at the time, data and place, and du	a to the cause(s) an	manner se stated					
= 5	Consult Unity			in my opinion, death occured at th							
NE S	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	IMBER	29d. DATE S	IGNED (Month, Day, Year)				
D BE CO	Tomothy	Kean ?	h.D.		7458	1 6,	21/75				
2 ≥	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CLUSE OF DEAT	TH (ITEM 27) (Type, Pr	rint)							
	TIMOTHY J. K!	AY, MD	DEPT F	M, 405 W. RI	EDWOOD S	T BAL	TIMORE MD				

405 W. REDWOOD ST BALTIMORE, MD



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

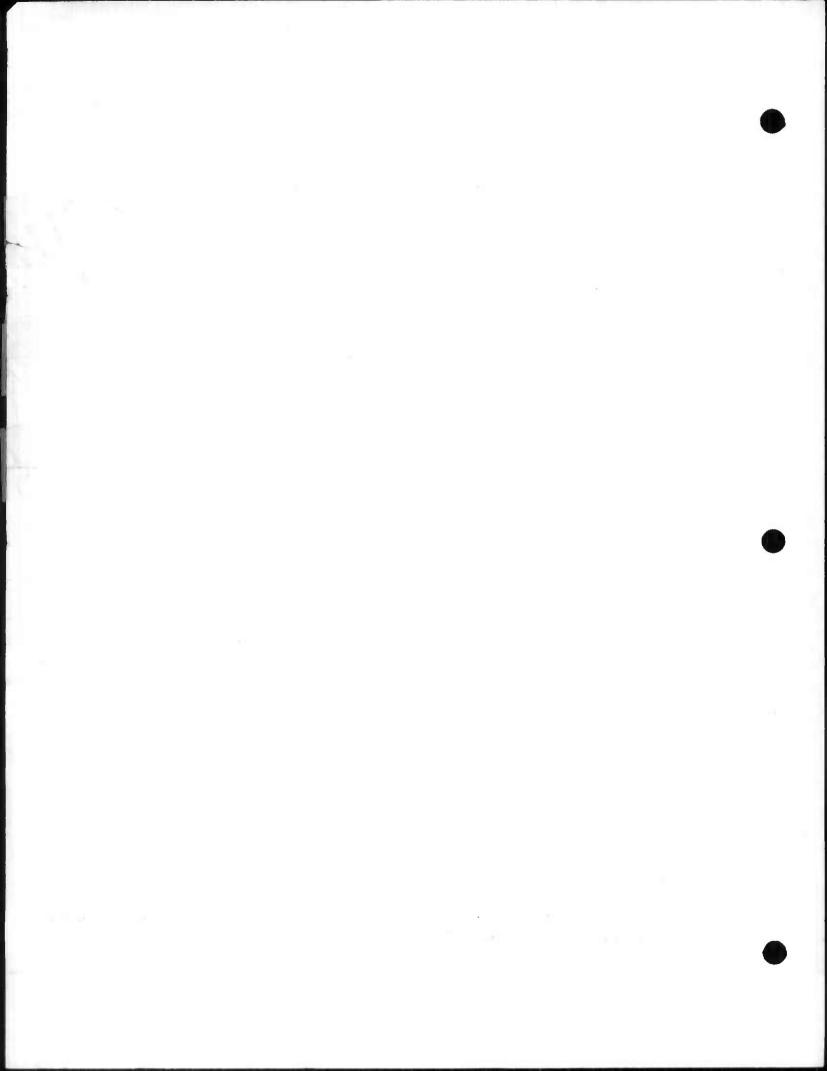
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - STATE REGISTRAR	STATE OF MA	RYLAND / DEPART	MENT OF H	IEALTH AND I	MENTAL HYGIE				
1. DECEDENT'S NAME (First, Mid ARTHUR	T.	AN	DERSON	Jr.	2. DATE OF DEATH	DAY YEA	3. TIME OF DEATH 05:40A		
4. SOCIAL SECURITY NUMBER 108–30–1563	5. SEX 6.		ONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Ybar)	8. B	IRTHPLACE (State or Foreign ountry)  New York		
	HOPKINS HOSPIT			TIMORE C	ATH	9c. COUNTY (			
10a. STATE 108  Maryland	COUNTY Howard	10c. CITY,	TOWN OR LOCAT	lumbia			10d. INSIDE CITY LIMITS? 1  YES 2 X NO		
10s. STREET AND NUMBER	ondback Driv	<i>r</i> e		ZIP CODE 2104	OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS  1 Never Married 2 X Marr  3 Widowed 4 Divorced	If yes, sp		IC ORIGIN? (Specify You, Puarto Rican, atc.)	3.0	RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondery (0-12)  College (1-4 or 5 +)  16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							RY		
4 Physical Scientist U.S. Army  17. FATHER'S NAME (First, Middle, Last)     Arthur T. Anderson Sr.  Bertha Ruth Goss									
19a. INFORMANT'S NAME (Types/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  9417 Diamondback Drive Columbia, Maryland 21045									
20s. METHOD OF DISPOSITION  1X Burlel 2 Crometion 3 Removal from State  4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY									
RO	an With	e h	Leroy	M & Russ	sell C Wit	'olumbia	eral Homes Maryland		
23. PART I. Enter the disease shock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentiely list conditions	meta	as a consequence of:	enter the mo	da of dying, auch	as cardiac or res	piratory arreat,	Approximata Interval Between Onset and Dasth  2 days  8 years		
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	۵	AS A CONSEQUENCE OF):							
PART II. Other significant c	onditione contributing to dea	nth but not resulting in	the underlying	g cause given in i	Part I. 24a. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 0 NO		
DID TOBACCO USE 25. WAS CASE REFERRED TO ME EXAMINER?		26. PLACE OF DEATH	(Check only one)	UNCERTAIN					
1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: Inpetient 2 - ER  28a. DATE OF INJ (Month, Day, V	/Outpatient 3 DOA 4	OF 28c. INJ	URY AT RK?	Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	D		
2 Accident Inves 3 Suicide 8 Coul	tigation 28s PLACE OF IN	JURY — At home, farm, stre (Specify)	M 1 1 Y		281. LOCATION (Street City or Town, State	and Number or Ru	rel Route Number,		
	IG PHYSICIAN: To the best of my						co(s) and manner to stated		
296. SIGNATURE AND TITLE OF		UD		29c. LICENSE NUM		29d. DATE SIGI	NED (Month, Day, Year) RE 22, 1995		
Johns Hopkins		ON:Wolfe:		Baltim	ore May	gland	21287		
JUNZ 3 1995	your Divolor	artials				_			



95-3609-510

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 95 JAMES SHELDON JUNE 20 BURKE 8:16 PM JR 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) NOV. 16, 1944 216-40-2253 DAYS 1 X M 2 - F 50 HOURS YRS PLAINFIELD, NJ Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CHURCH HOSPITAL BALTIMORE CITY n/a 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1901 Ε. LOMBARD STREET use as the burial-transit 21231 UNITED STATES retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Nerried BY Specify BLACK 3 Widowed 4 Divorced ARMY 7-66 -- 7-68 COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 1 yr. SALESMAN RETRIL SALES 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Maiden Surname) **JAMES** SHELDON BURKE SR. GRACE HAMMOND BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LEAH BURKE 1901 LOMBARD ST, BALTIMORE, MD hours after death. Page 6 may be be 20e, METHOD OF DISPOSITION

∧⊘ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must GARRISON FORESTV 4 Donation 6 Other (Specify) A C EM 26 6-OWINGS MILLS.MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEF 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE n by the f removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by Approximate shock, or heart feliure. Liet only one cause on each line. Interval Between 8 IMMEDIATE CAUSE (Final Onset and Death cremation. disease or condition the REURL PAILURE event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): an and com HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed traumatic CERTIFICATION Sequantially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): ental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST by the atten PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? DIDWALRY MELLINS Signed Health a 1 YES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: XXYES 2 NO 1 Inpetient 2 PER/Outpetient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DEŞCRIBE HOW INJURY OCCURED this c marked, 1 Netural 5 Pending 1 YES 2 NO BY After death 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 90 COMPLETED DIRECTOR: A hours after of item 28 is 8 Could not be 4 Homicide determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTO be filed within 72 hours aff IMPORTANT. If item 28 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attend. 2 X MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated. ATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) Weynte O.C.M.E. JUNE 21,1995 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. KORon MARGARIONS M 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year)

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within schours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

30. NAME AND ADDRESS OF PERSON

JUN 2 3 1995

HAM

						95	18878			
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)  OLTVER	BUDD-JR			2. DATE OF DEATH DO TUNE 7	0 1995	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 220-76 -1626	5. SEX 6. AGE (In yrs. last	t birthday) IF UNDER MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT. 14,	e nier	THPLACE (State or Foreign ALTIMORE, MD			
OR	9a. FACILITY NAME (If not institution, give s UNDON MEMC	NZIAL HOSPIT		TOWN OR LOCATION OF DE	EATH	9c. COUNTY OF				
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	Y	10c. CITY, TOWN C	R LOCATION			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	n/a	BAI	TIMORE			VX YES 2   NO			
ERA	1613 E. 31 s	t STREET		2121	8	UNITED	) STATES			
BY FUNERAL	11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARE FORCES? 1 YES 2 XN IF YES, GIVE WAR OR DATES	10	MAS DECENDENT OF HISPAN f yes, specify Cuben, Maxice TES 2 XNO Specify	NC ORIGIN? (Specify Yes	or No- 14. RAG	CE — American Indian, cik, White, etc.			
	m s money s modey									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  13 th  LABORER  16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) life. Do NOT use retired.)  LABORER  17. FATHER'S NAME (First, Middle, Last)  OLITYED DILIDD SD  18. MOTHER'S NAME (First, Middle, Melden Surgame)										
BE COM	17. FATHER'S NAME (First, Middle, Last) OLIVER BUDD	SR.			ME (First, Middle, Maiden WEL WAL	Surneme)				
TO B	19a. INFORMANT'S NAME (Type/Print) OLIVER BUDD		HAILING ADDRESS	(Street and Number or Rural I E. 31 st			,MD 21218			
	20s. METHOD OF DISPOSITION 1	CATION — City of T								
	21, SIGNATURE OF FUNERAL SERVICE LIC		NMOUNT Plece)	WM. C. MARC	CILITY					
	23. PART I. Enter the diseases, or	complications that caused the det List only one cause on each line.	eth. Do not enter	the mode of dying, suc	h as cardiac or respi	ratory arrest,	Approximate			
	IMMEDIATE CAUSE (Final	a. OLOPATH  DUE TO (OR AS A CONSEC		ATEN CA	DDIAMYA	DATHY	Interval Between Onset and Death			
		DUE TO (OR AS A CONSEC	DUENCE OF):		101.70	1-111/-	1			
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEC	DUENCE OF):							
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO	DUENCE OF):							
	PART II. Other significant condition	a contributing to death but not m	esulting in the un	deriving cause given in	Part I. 24a, WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS			
S					PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?			
PHYSICIAN: MEDICAL	DID TODA GGO LIGA GOLIA				_		1 - YES 2 NO			
AN	DID TOBACCO USE CONTI		TH YES N	TO EL OTTOERNA	1 🛛					
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	OTHER		8 Other (Specify)					
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? t YES 2 NO	28d, DESCRIBE HOW IP	JURY OCCURED				
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — Al hon building, etc. (Specify)	me, farm, streaf, facto	ory, office	261. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,			
COMPLETED		CIAN: To the best of my knowledge, des					(a) and menner se stated			
ш	296. SIGNATURE AND TITLE OF CENTIFIER									
10 8	C H	29G. LICENSE NUMBER  29G. LICENSE NUMBER  29G. DATE SIGNED (MONTH), Day, Year)  29G. DATE SIGNED (MONTH), Day, Year)  29G. DATE SIGNED (MONTH), Day, Year)								

) MO HOUSE OFFICER

D) MO UNION MEMOR

32 AEGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760. TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wi IMPORTANT: If Item 28 is marks

	Pages 1. 2. 3 should		
ospital or attending physician.	ched for use as the burial-transit permit		
retained by the h	5 should be detact		and of balling
ige 6 may be	director, page		to miss he an
after death. P.	y the funeral	noval.	cal evamine
SUDOUL	ely filled in b	nation, or ren	the medi
executed with	and complet	to burial, crem	matic event
certificate be	iding physiciar	Hygiene prior	arked or item 23 shows any injury or other traumatic event the med
nat the death	d by the atten	and Mental I	ny injury o
aw requires t	this certificate has been signed by t	pt. of Health	3 chowe a
N: I he 12	icate has	State De	Item 2
SICIA	certif	h the	1 or
H	r this	h with	arket

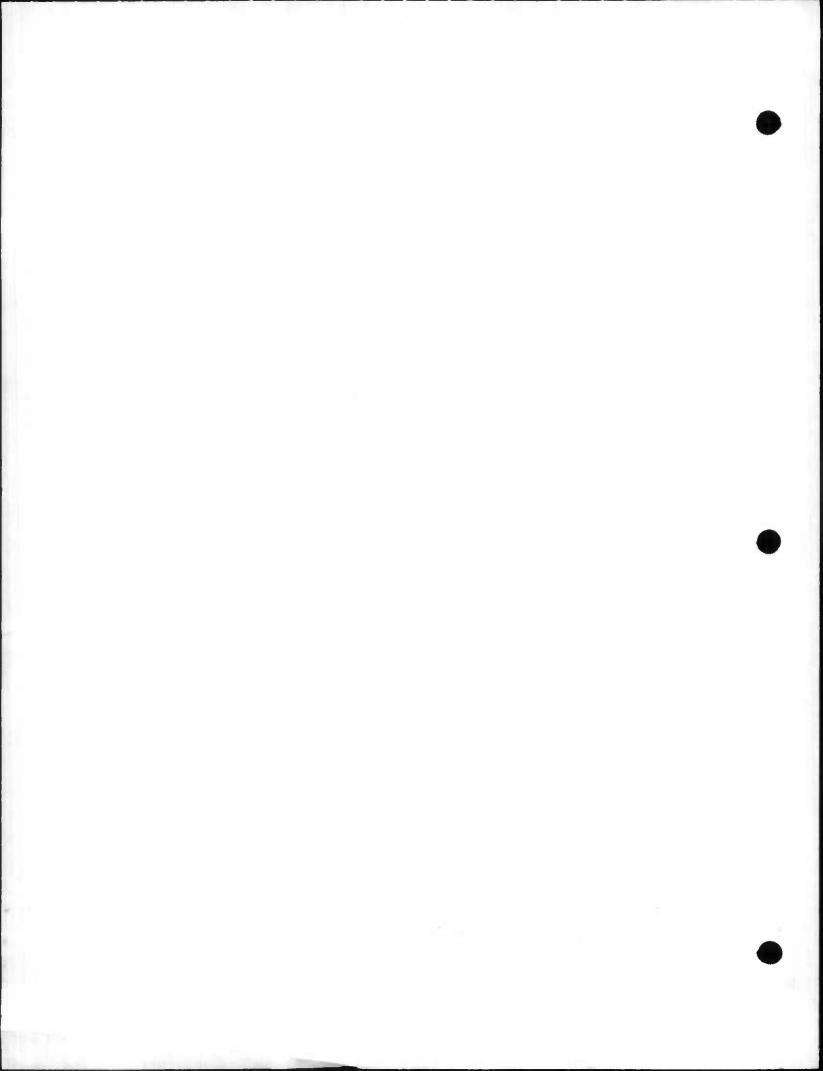
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFIC			MENTA	L HYGIENE			
	1. DECEDENT'S NAME (First, Middle, Last) Julia Louise	Boone				2. DATE	OF OEATH	1995	3. TIME OF DEATH 9:30 A. M	
1	4. SOCIAL SECURITY NUMBER 183-14-8733	5. SEX 6. AGE (In yr. 1		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont May	OF BIRTH h, Day, Year) 6, 192		HRTHPLACE (State or Foreign Sountry) Maryland	
TOR	96. FACILITY NAME (If not institution, give street end number)  7018 Heathcoate Drive  RESIDENCE OF DECEDENT  96. COUNTY OF DEATH  Kingsville  Baltimo									
DIRECTOR	10e. STATE 10b. COUNTY	rford Abingdon						10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	100. STREET AND NUMBER 500 Ramblewood 1	Prive, Apt.10	8A	101. ZIP CODE 21009				10g. CITIZEN	OF WHAT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 M Merried 3 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	<b>∑</b> NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Not if yes, specify Cuben, Maxican, Puerto Ricen, etc.) 1  YES 2 X NO Specify:					14. RACE American Indian, Black, White, etc.  Specify: White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 8th grade	ATION 184 completed) College (1-4 or 5+)	Give kind of work life. Do NOT use re	k done during most of working efired.)					RY	
COM	17. FATHER'S NAME (First, Middle, Last) Howard Cole				18. MOTHER'S NA			, ,		
TO BE	190. INFORMANT'S NAME (Type/Print)  John Funkhouser	(son-in-law)			nd Number or Aural ate Driv					
	20s. METHOD OF DISPOSITION  1 X Burlel 2 Cremetion 3 Removal from State  4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of gametery, premeipry or other place)  KNACLY S CEMETERY  6/24 Westminster, MD									
	21. SIGNATURE OF FUNERAL SÉRVICE LICENSEE)  22. NAME AND ADDRESS OF FACILITY SCHEMUNER FUNERAL HOMES, Inc. 9705 Belair Rd., Baltimore, MD 21236									
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart fellure. List only one cause on each lina.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Due To (OR AS A CONSCOUENCE OF):  Blunch of Orangan Connect.									
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other significant conditions	contributing to deeth but n	not reaulting in the	ne underlylng	g cause given in	Pert i.	PERFORMED?		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	DID TOBACCO USE CONTR		DEATH YES		UNCERTAI	N 🗆			1 YES 2 NO	
PHYSICIAN:	EXAMINER?  1   YES 2   NO	HOSPITAL: 1   Inpatient 2   ER/Outpatient	01	THER:	5 Hesidence	8 🗆 Othe	r (Specify)			
ву РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME OF INJURY	WO		28d. DES	CRIBE HOW INJ	URY OCCURE	D	
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — A building, etc. (Specify)	it home, farm, atree	t, factory, office			ATION (Street end or Town, State)	1 Number or Ru	ural Route Number,	
COMPLETED		IAN: To the best of my knowledge : On the besis of exemination and							use(s) end manner es stated.	
TO BE C	296. SIGNATURE ON THE OF CERTIFIER	B Mil	la m		29c, LICENSE NUI	ABER			VED (Month, Gey, Year) 23691-	
	30. NAME AND ADDRESS OF PERSON WHO Dr. Michael Dillo	n, 7505 Osler	Dr., Sui		, Baltim	ore,	MD 21	204		
	31. DAJUN 2 3 1995 Jul	A REGISTRAR' SIGNATU	IE .				-			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTM			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN	-	3. TIME OF OEATN		
	NELSON	P	T:	BERGI	ER		20 199°			
			E (In vis. last birthday) IF INDER 1 YEAR IE INDER 24 MRS 7 DATE OF BIRTH					HRTHPLACE (State or Foreign		
	213 07 0717	000.7,770								
OR	Good Samaritan Ho	tan Hospital Baltimore N/								
<u> </u>	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c CITY TO	OWN OR LOCAT	ION			10d. INSIDE CITY		
DIRECTOR	Maryland 1	V/A	1000 0111, 10	Balti				LIMITS?		
AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	6000 Moravia Park	Drive C3			21206		u. s	S. A.		
5	11. MARITAL STATUS 1 1 Never Merried 2 Married	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	ARMED	13. WAS DECI	ENDENT OF NISPA	NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	a or No- 14. I	RACE — American Indian, Black, White, atc.		
8	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TES	2 NO Specif	fy:		Specify:		
	15. DECEOENT'S EDUCAT	CION 18a	. OECEDENT'S USU	AL OCCUPATIO	M	40, 400, 05 0	ISINESS/INOUSTI	White		
ET	(Specify only highest grade co.	mpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use rel	done during mos	at of working	IOD. KINO OF BO	> /*	NY .		
7	8th Grade	Surage (1-4 or 5+)	Tester			CGR Mo	dical C	Corporation		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maider		oxportation		
BE C	John Berger			Burkhardt		-				
0 8	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox				
F	Edwin Stewart (Bro	ther-in-law)	8203 W	ilson A	lve., Ba	ltimore, N	laryland	1 21234		
- 1	20a, METHOD OF DISPOSITION 1 A Buriel 2 Cremetion 3 Remove	20b. PLA	CE AND DATE OF O	SPOSITION (Na		OATE 20c. LC				
	4 Donation 5 Other (Specify)	Gard	Lens of	Faith	6/	23/95 Ba	ltimore	. Maryalnd		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		SCHUI	DADDRESS OF FA	neral Home				
	Robert Adack, Jane, Baltimore, Md. 2121									
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, ahock, or weart feliure. Liet only one cluse on each line.  IMMEDIATE CAUSE (Finel disease or condition									
	resulting in death)  a. SEPSIS  DUE TO (OR AS A CONSEQUENCE OF):									
-	Sequentially Het conditions 6. Preumania									
2	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):									
3	ceuse. Enter UNDERLYING									
E	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	reaulting in deeth) LAST									
AL C	PART II. Other aignificent conditions of	contributing to death but n	ot recuiting in th	ne underlying	ceuee given in	Part i. 24a. WAS AF	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
	Conjustive hear		· Celly	1 . 1 .	- Hypen	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
	Renal insulli	clency - c	deliriu	200	11	1 123	2 DAILO	OF DEATN?		
ä	DID TOBACCO USE CONTRIE		EATH YES	□ NO □	UNCERTAI	NO				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		LACE OF OEATN (C							
Sic		OSPITAL:  Impetient 2 ER/Outpetient		HER: Nursing Nome	5 - Residence	6 Other (Specify)				
H	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	28c. INJU		28d. DEŞCRIBE NOW	INJURY OCCURE	D		
B	1 Natural 5 Pending 2 Accident Investigation			M 1 7	ES 2 NO					
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — Ai building, atc. (Specify)	t home, 1erm, stree	l, lectory, office		281. LOCATION (Street City or Town, State	and Number or Ru )	iral Route Number,		
۳	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the beat of my knowledge	death occurred at	the time date	and place, and due	to the source(s) and m-				
M M		On the besis of examination and						se(a) and manner se stated		
	296. SIGNATURE AND TITLE OF CERTIFIER			1	29c. LICENSE NUI					
8	C7-A. T	ensolar.	MO		1111	7242	D A L	NED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO C	ONPLETED CAUSE OF DEATH (	ITEM 27) (Type, Prin	1)	100	1216	00	100/75		
	MUHAMMAD 2	ZAYDAN, M	1.D	Goo	d 5	amani da	140	ocpital.		
	JUN 2 3 1995	THE PROPERTY OF	34					/		



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

215-30-8019

Theodore Sears Ballard

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9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 5257 Wentz Rd. Manchester DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 18b. COUNTY 10c. CITY, TOWN OR LOCATION Carroll Manchester Md. permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE burlal-transit 5257 Wentz Rd. 21102 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced the funeral director, page 5 should be detached for use as the Conflict Korean ED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INQUSTRY during most of working (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet Maker Custom Furnature 12 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irma Evelena Sears notified at Grason Elmer Ballard 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Audrey L. Ballard 5257 Wentz Rd., Manchester, Md. 21102 a 20a, METHOD OF DISPOSITION
1 A Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — Cify or Town, State OATE must Lineboro Cemetery June 26,1995 Lineboro, Md. 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 21. SIGNATURE OF FUNDEAL SERVICE LICENSES after death. -· Cellian 3296 Charmil Dr., Manchester, Md. 21102 23. PART I. Enter the diseases, or complication thank or heart failure. List only medical s thet coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart failure. List cause on each line 50 **IMMEDIATE CAUSE (Final** cremation, the diseese or condition Mus Schliche completely resulting in death) or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF). burial, CERTIFICATION and Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to 8 CAUSE (Diseese or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY certificate has been signed by h the State Dept. of Health and shows any 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem EXAMINER? OTHER: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 6 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26c. INJURY AT WORK? with t marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Matural 84 1 YES 2 NO FUNERAL DIRECTOR: After t within 72 hours after death BY Accident 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, stc. (Specify) .00 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide Hem 1 CENTIF death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 his important. If it ed at the time, data and place, and due to the cause(s) and manner as stated. LICENSE NUMBER BE 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year)

Souder Rond

2 3 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

6. AGE (In yrs. last birthday)

YRS.

63

Dollard

HOURS

MIN.

IF UNDER 1 YEAR | IF UNDER 24 HRS.

DAYS.

2. DATE OF DEATH 6

7. DATE OF BIRTH

(Month, Day, Year) May 11, 1932

95 18881

B. BIRTNPLACE (State or Foreign

10d. INSIDE CITY

1 YES 2 NO

Approximete

24b. WERE AUTOPSY FINDINGS

OF DEATH? 1 TYES 2 NO

29d. DATE SIGNED (Month, Day,

ZZ May

AVAILABLE PRIOR TO COMPLETION OF CAUSE

Interval Between

Onget and Death

Maryland

9c. COUNTY OF DEATN

Carroll

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. RACE — American Indian, Black, White, etc.

Specify: White

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O. BOX 68	and the same in the same in the
P.O. BOX 68	the new differents for a new day
S. P.O. BOX 68760 BALTIMORE, MARYLAN	nath and March has not a

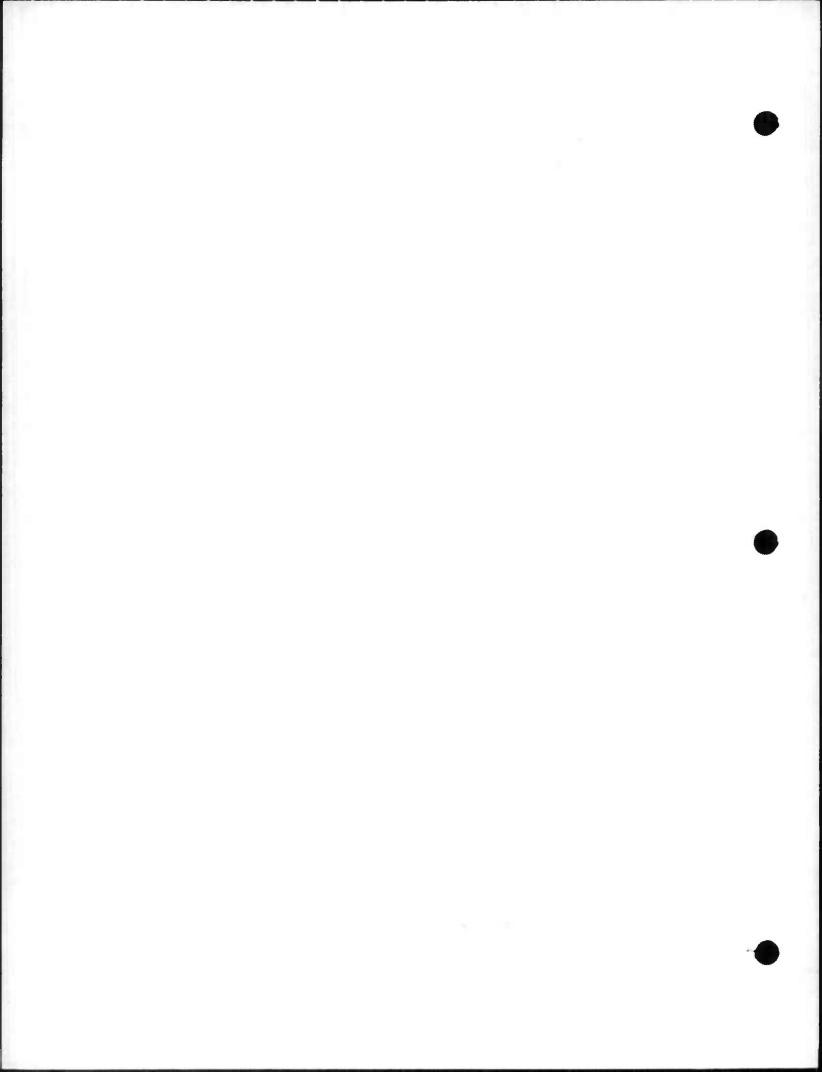
DIVISION OF VITAL RECORDS,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 75 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

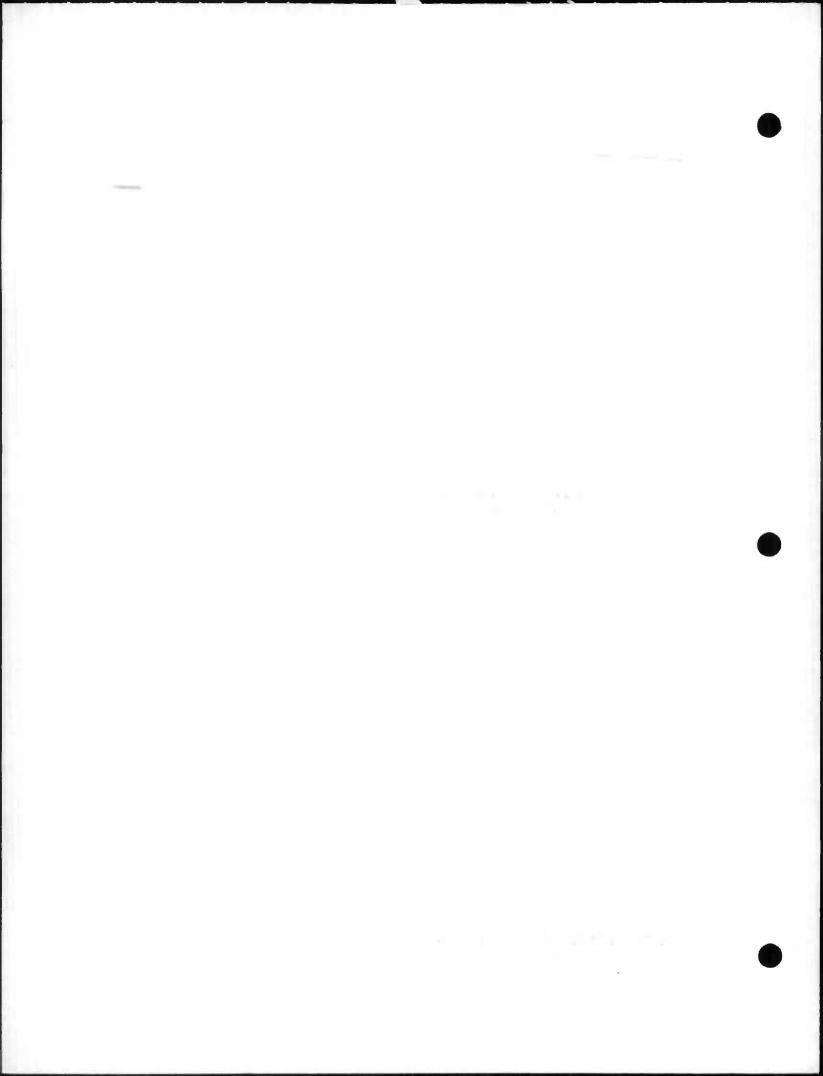
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. JD 21215-0020

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	AL HYGIEN	E		
	1. OECEDENT'S NAME (First, Middle, Last)			-		2. DAT	E OF OEATH			3. TIME OF OEATH
	KATHLEEN		BUCKMASTER				VE 22,		EAR	06:00A M
	CVI CONTRACTOR CONTRACTOR	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BHRTH MONTHS DAYS HOURS MIN. (Month, Day, Year)						8.	BIRTHP	LACE (State or Foreign
	21/-40-4001	7-46-4801 1 M 2X F 49 YRS. AUG						945 N		
Œ	90. FACILITY NAME (If not institution, give stree THE JOHNS HOPKIN	1		R LOCATION OF E			9c. COUNT		ATH	
0T.	RESIDENCE OF DECEDENT	5 HUSPITAL		BAL	TIMORE	CITY		N,	/A	
REC	10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCAT				(	10d, INSIDE CITY		
ā	Maryland Balti	Arb	Arbutus					1 TYES 2 TYNG		
FUNERAL DIRECTOR	10e, STREET AND NUMBER			101			10g. CITIZE	N OF WI	IAT COUNTRY?	
NE	5520 Thomas Ave				21227				ted	States
	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEOENT EVER I FORCES? 1 YES	2 NO	If yes, sp	ENOENT OF HISPA	en, Puerto	N? (Specify Yes Rican, etc.)	or No 14	Black,	- American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 YES 2 NO Specify:					Specify	hite
COMPLETED	15. OECEDENT'S EDUCAT (Specify only highest grade co	FION (Consistent)	16a. DECEDENT'S U	SUAL OCCUPATION	N N	16	b. KINO OF BUS	SINESS/INDUS		IIIce
LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	ille. Do NOT use	id af work done during most of working IOT use retired.)						
MP	12 cashier							pita1	L	
	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S N			,			
BE	Loyed B. Krone	DOBECS (Street a	Cat nd Number or Rura	heri	ne Ar	ata F	ro	ner		
5	Michael Buckmas	ter								and21227
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State									
	4 Donation 5 Other (Specify)	V V	netery, crematory or other	dae Ce	meterv	6/2	6 Dor	sev.	Mai	rvland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	10	22. NAME AN	O AODRESS OF F	ACILITY				
	I to the		-6.		se Fun Hammon					
	e3. PABT I. Entar the diseases, or cor shock, or heart failure. Lis	nplications that cause	d the death. Do no	t enter the mo-	de of dying, su	ch as car	diac or reapi	ratory arres	t,	Approximate
9	IMMEDIATE CAUSE (Final	AL STREET		1.6	-					Interval Between Onset and Daath
	TIMMEDIATE CAUSE (Final disease or condition resulting in death)  Therefore the control of the c								72 hours	
	OUE TO (OR AS A CONSEQUENCE OF):  (1) Parietal arteriorenas wal fervation									
NO N	Sequentially list conditions,  our To lor as a consequence of):									
CAT	cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF):	CONSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST									
	PART II. Other significant conditions	contributing to death t	out not resulting in	the underlying	cause given in	Part I.	24a, WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS
2							PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
WEL							, , , , , ,	110		F OEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRII	BUTE TO CAUSE C	F DEATH YES	□ NO □	UNCERTA	N Z				113
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)						
IXSI	1 YES 2 BAO 1	Impatient 2 - ER/Outp	patient 3 DOA 4	☐ Nursing Hom	5 Residence	6 🗆 Oth	er (Specify)			
	27. MANNER OF OEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	YY WO	RK?	28d. DE	SCRIBE HOW II	JURY OCCUP	ED	
BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	/ — At home, farm, str	M 1 V		281 1.04	CATION /Stead of	nd Mumber or	Drumi Do	the Afronder
回	4 Homicide B Could not be determined	building, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	281, LOCATION (Street and Number or Rural Route Number, City or Town, State)				ae Number,	
COMPLET	290. CERTIFIER (Check only	N: To the best of my know	ledge, death occurred	at the time date	and place, and du	a to the co	use/s) and man			
OME	one) 2 MEOICAL EXAMINER:								ause(s) i	and manner es stated.
Ü	29b. SIGNATURE AND TITLE OF CERTIFIER			,	29c. LICENSE NU					
0	2012e uno no	e wresty	Posidor	4	1990	2		29d. DATE SIGNED (Month, Day, Year)  July 27, 1995		
2	30. NAME AND ADDRESS OF PERSON WHO	OMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type, P	rint)						
	, , , , ,	0 - /	11 1 .	1	1 1					
	Victer Ring	uno Jah	us (topki	ra Hos	piters					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

Ite	m#9.c.G-film	724 p											20	10000
	1 - STATE REGISTRAR		STATE OF I	MARYLAN	ID / DEPA CERTII	RTMEN FICAT	T OF H	DEAT	AND N	MENTAL	HYGIEN REG. NO			
	t. OECEDENT'S NAME (First	THEP	LES-A	Bor	MEN					2. DATE C MONTH JUNじ	D/	AY .	195	3. TIME OF DEATH  0820 PM
	4. SOCIAL SECURITY NUMBER 718	ER	5. SEX		rs. lest birthday	IF UNDE	R 1 YEAR DAYS	IF UNDER	24 HRS. MIN.		Day, Year)	20	8. BIRT Coun	
	9e. FACILITY NAME (if not institution, give street end number)				-	9b. CIT			ON OF DE		15,19	V	NTY OF	
TOR	St. Agnes Hospital					B	alti	nore				N?A		
DIRECTOR	too. STATE Maryland	10b. COUNT	, Baltimore		10c. C	TY, TOWN			ville					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER						. ZIP COD		=		10g. CIT	IZEN OF	1 YES 2 XNO	
FUNERAL	715 Maiden	Choic		PV					1228					S.A.
BY FU	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			S NO	13.	It yes, sp	ecify Cubs		n, Puerto Ri	(Specify Yes can, etc.)	or No—		E — American Indian, ok, White, etc.	
TED	ts, DEC (Specify oni	EDENT'S EDU y highest grade	CATION completed)	16	Give kind a	work done	durina mo	ON ast of workin	ng	16b. I	KINO OF BUS	SINESS/INI	DUSTRY	
COMPLET	Elementary/Secondary (f	0-12)	College (1-4 or 5	+)		make					Own H	ome		
i iii	17. FATHER'S NAME (FIRST, M. William A.		S						HOT 1		iddle, Maiden	Surneme)		
10 B	Sally Grif:		Daughter	)	19b. MAILIN 244 C	g ADDRES rala	s (Street e	ad Ca	or Rural R	oute Numbe SVill	e, Ma	n, Stete, Zij rylai	nd 2	1228
	20e. METHOD OF DISPOSITION  t						5		20	DATE				own, State
	21. SIGNATURE OF EUNERA		CENSEE	, /	/)	22.	NAME AP	ID ADDRE	SS OF FAC	CILITY				lle,Maryland
	B.C	rai,	With	ke of		11	630	Edmoi	ndsor	a Ave	nue C	aton	svil	ral Homes le Maryland
	23. PART I. Enter tha d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart failure.	Liet only one cat	ise Dn each	iline.								reat,	Approximate Interval Between Onset and Daath
CERTIFICATION	disease or condition realition realiting in death)  Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Longestive Heart faulure  I. week  Congestive Search  Adriamyon - induced cardiomyopathy  But TO (OR AS A CONSEQUENCE OF):  Metastative breast cancer.  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):								3 years.					
EDICAL (	PART II. Other algolfice	ent condition	e contributing to	death but	not resulting	In the u	nderlying	g couse (	jiven in F		24a. WAS AN PERFOR	MED?	241	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	DID TOPACCO II	CE (O) III								_				OF DEATH? 1 ☐ YES 2 ☐ NO
PHYSICIAN:	DID TOBACCO U		RIBUTE TO CA		PLACE OF DE			UNC	ERTAIN	10				
YSIC	EXAMINER?		HOSPITAL: 1√Inpatient 2 [				rsing Nom		sidence (	6 🗆 Other	(Specify)			
		Pending Investigation	26a. DATE OF (Month, D		26b. Ti	ME OF JURY M		URY AT RK? /ES 2	NO	26d, DESC	RIBE HOW II	NJURY OC	CURED	
TED BY	3 Suicide 6	Could not be determined	26e. PLACE Obuilding,	F INJURY — etc. (Specify)	At home, farm,	street, tec	tory, office			261. LOCAT City or	TtON (Street a Town, Stete)	and Number	or Rural	Route Number,
COMPLET			CIAN: To the best of a											s) end manner es stated.
29c. LICENSE NUMBER							8ER		29d, DAT	E SIGNED	(Month, Day, Year)			
TO B	30. NAME AND ADDRESS OF	PERSON WH		SE OF DEATH	(ITEM OF /	a Butani da		b 4	896	3		<b>&gt;</b> J	ine	22 1995
	Clarence	Sanko	dee-Hole	vo wy		-	00 f	Cat	en t	Aven	re, E	Balt	iner	22 995
	JUN 2 3 19	195 A	32 REGISTRA	or land	II.									



permit. Pages 1, 2, 3 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 page 5 should funeral director, requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 attending physician

must be the medical examiner completely filled in by the frial, cremation, or removal, inding physician and completely filled in Hygiene prior to burial, cremation, or traumatic event, or other signed by the atter Health and Mental Injury, shows any L. of h has be Deot. 23 OR ATTENDING PHYSICIAN: The law Hem certificate h

marked, or the state

BY

COMPLETED

BE

9

this (

After death

TO THE HOSPITAL OR ATTENDING
TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deal IMPORTANT: If Item 28 Is m

27. MANNER OF DEATH

5 Pending

6 Could not be

determined

1 Netural

2 Accident

3 Suicide

4 Homicide

once.

notified

B.K.S 18884 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 194, 19955 CHARLIE FRANK **BRANHAM** JUNE 1340 P 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH HOURS Ge 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF CEATH WINCHESTER STREET APT.C DIRECTOR 2412 BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Ka Vlana more 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2412 2 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cultur, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. 14. RACE — American Indian, Black, White, atc. If yes, specify Culture

1 ☐ YES 2 ☑ NO 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: Specify: 3 Widowed 4 Divorced COMPLETED 15. OECEOENT'S EOUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ndary (0-12) College (1-4 or 5+) ntenanc BE 2 20a. METHOD OF DISPOSITION
1 1 Burlel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITIO 6 Other (Specify) 21. RIGNATURE OF FUNERAL SERVICE MICENSEE Joseph 2222 u Enter the discesse, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on sech line. Approximate IMMEDIATE CAUSE (Finel Onset and Death disease or condition Spas Multiple resulting in death) OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL:

OTHER:

28c. INJURY AT WORK?

1 YES

4 - Nursing Home Na Rasidence 6 - Other (Specify)

28d. OEȘCRIBE NOW INJURY OCCURED subject Spesed 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29s. CERTIFIER
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.

26b. TIME OF INJURY

28s. PLACE OF INJURY — At home, 1srm, street, 1sctory, office building, stc. (Specify)

1310 4

29b. SIGNATURE AND TITLE OF CERTIFIER JUNE 20, 1995 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

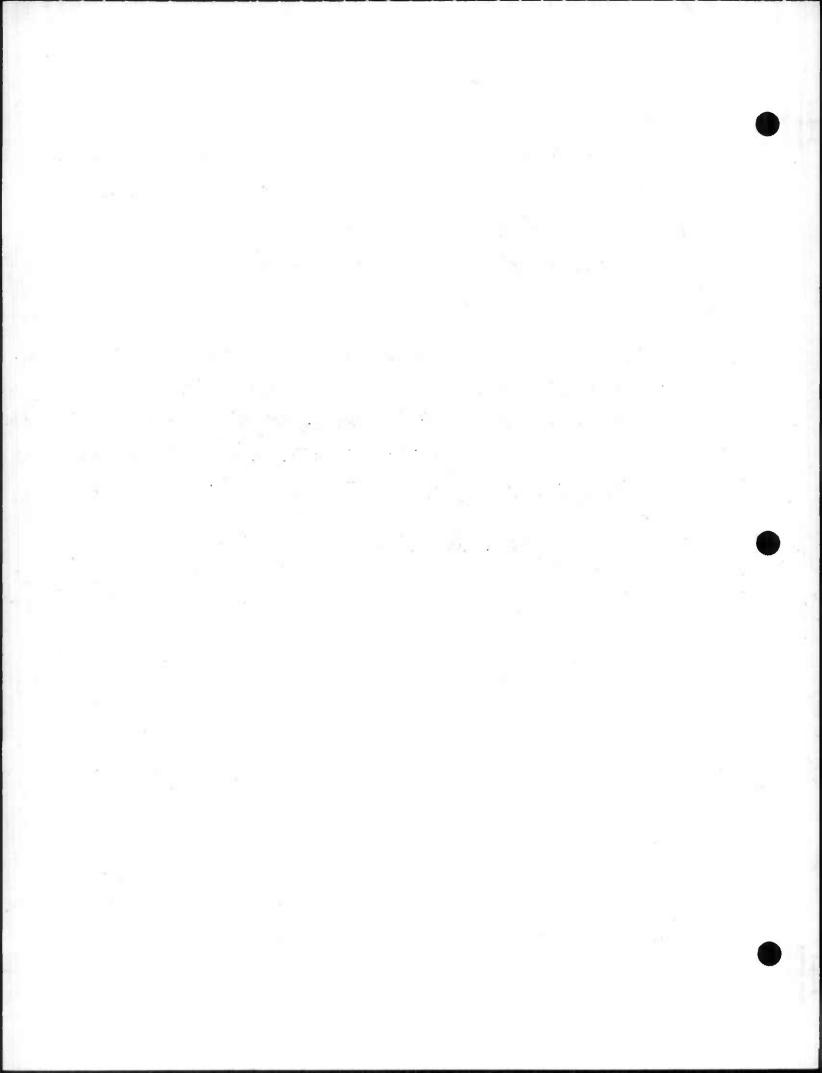
1 Inpetient 2 ER/Outpetient 3 DOA

(Month, Day, Year) Found

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

wid Powler Julia d'assessiones de la lige



Items# 10.b.10.c.G-film 724 per F.H 6/23/95 P.C
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH BUCHHEISTER 540 JUNE 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 2-14-12 212-05-79151 - \* 32 5 83 Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital NA Baltimore Md. RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Overlea Maryland
100. STREET AND NUMBER Baltimore 1 YES 2 NO Dermit, FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 107 Manor Ave 21206 USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? FORCES? 1 YES 2 NO 1 Never Married 2 Married BY 3 Widowed 4 ☐ Divorced Specify White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Homemaker NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Naiden Surname) # BE Anton Vancura Theresa Svitek notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3502 Goldenrod Lane Baltimore, 21234 Mary T. Davis 9 20a. METHOD OF DISPOSITION
15 Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 29c. LOCATION - City or Town, State must of Gardens Faith Cem 6-23-95 Baltimore, Co. 21. SIGNATURE OF HUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Dippel FH, 7110 Belair Rd. 21206 ion, or removal. medical 23. PART/ Enter the diseases, or confplications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Batween IMMEDIATE CAUSE (Fine) Onset and Death and completely fille burial, cremation, the GRAM NEGATIVE SEPSU disease or condition DAYS resulting in death) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 executed with DUE TO (OR AS A CONSEQUENCE OF) HEART FAILURS CONGESTIVE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a mal Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be INTESTINAL CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 n signed by the attent injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 | YES 2 | NO OF DEATN? Shows 1 TYES 2 NO been 1. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \overline{\overl PHYSICIAN: has be Dept. HOSPITAL DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) item certificate h HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Rasidence 6 Other (Specify) 0 the 27. MANNER OF DEATH 28s. DATE OF INJURY this c 28d. DESCRIBE HOW INJURY OCCURED marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Natural 1 YES 2 NO BY investigation After death 2 Accident 28s. PLACE OF INJURY — At home, larm, street, lactory, offica building, etc. (Specify) 65 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be hours after Hem 28 is DIRECTOR: 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL within 72 h IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 世世紀 2 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NAZARE BALTO 32 REGISTRAR'S SIGNATURE

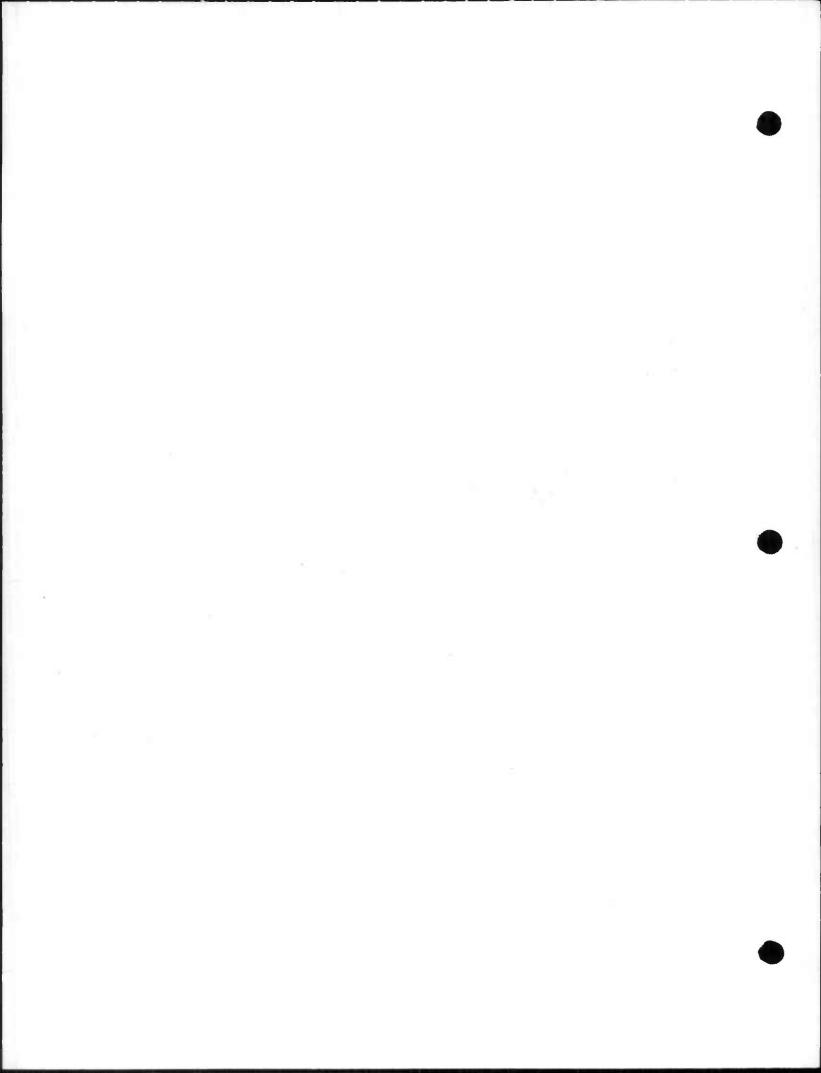
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	1 - FOR STATE REGISTRAR	OF MARYLAND / I	DEPARTMENT OF		NTAL HYGIENI	E			
	1. DECEDENT'S NAME (First, Middle, Lest)			2	DATE OF DEATH DA	Y YEAR	3. TIME OF DEATH		
	Elizabeth	<u>Elizabeth</u> <u>Beyerling</u> <u>June</u>							
	213-28-5656 1□ м 21/2	8. SEX 1 M 2XX F 85  9. AGE (In yrs. last birthday)  1 D M 2XX F 85  1 VRS.  1 D MONTHS DAYS HOURS MIN.  1 DAYS HOURS MIN.  1 DAYS HOURS MIN.  1 DAYS HOURS MIN.  1 DAYS HOURS MIN.  1 DAYS HOURS MIN.					1909 Maryland		
Œ	9a. FACILITY NAME (If not institution, give street and numb			OR LOCATION OF DEATH	Н	9c. COUNTY OF	DEATH		
DIRECTOR	3939 Roland Aven	ue Unit 50	94   Balt	imore		N/A			
IRE(	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOC				10d. INSIDE CITY LIMITS?		
	Maryland N/A		Baltin	Ore		1 X YES 2 NO			
FUNERAL	3939 Roland Avenue	Unit 504		21211			SA		
J.	11. MARITAL STATUS 12. WAS DE FORCES	CEDENT EVER IN U.S. ARM	TED 13. WAS DO	ECENDENT OF HISPANIC (	ORIGIN? (Specify Year Puerto Rican, etc.)	or No- 14. BA	CE — American Indian, ck, White, etc.		
BY	3XXWidowed 4 Divorced IF YES,	GIVE WAR OR DATES	1 🗆 YI	S 2 X XIO Specify:	•	Spe	White		
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Gh)	EDENT'S USUAL OCCUPATE kind of work done during it		16b. KIND OF BUS	INESS/INDUSTRY	MITTE		
COMPLETED	Elementary/Secondary (0-12) College (1-4	( or 8 +)	NOT use retired.) Homemaker		Own	Home			
Ö	17. FATHER'S NAME (First, Middle, Last)		Homemarer	18. MOTHER'S NAME	(First, Middle, Maiden \$				
BE	Charles Judson Dimm	ling		Laura		Lam	0		
5	198. INFORMANT'S NAME (Type/Print)  Susan Lidard		MAILING ADDRESS (Stree						
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from Str	20b. PLACE AN	2025 Reuter			Marylan(			
	4 Donalion 6 Other (Specify)	Greenm			6/22 Bal	timore.	Marvland		
- 1	21. SENATURE OF FUNERAL SERVICE LICENSEE	10. 1	22. NAME	AND ADDRESS OF FACILITY	hell-Wied	efeld Ho	ome		
-	23. PART I. Enter the diseases, or complication	Menas	6500	York Road	Raltimoro	Manyl	and 21212		
	ahock, or heart fellure. List only on	e ceuse on each line.	un. Do not enter the n	lode of dying, auch a	s cardiac or respir	ratory arrest,	Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	ide,	miso	con	u	6	one de		
	DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	UE TO ION AS A CONSEOL	JENCE OD:	2 - 1 0	Ven		1.		
S	CAUSE (Disease or Injury	UE TO (OR AS A CONSEQU	IENCE OD:	2011			podo.		
F	that initiated events resulting in death) LAST	TO ON AS A CONSECU	JENCE OF):				,		
	PART II. Other algorificant conditions contributi	ng to deeth but not re	aulting in the underlyi	ng causa gluan in Bas	T.I. 24s. WAS AN A	u deservició de la constante de la constante de la constante de la constante de la constante de la constante de	A MISSION OF THE PARTY OF THE P		
ICAL	000		outling in the original	ng couse given in rai	PERFORM		b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
MED					7	100	OF DEATH?  1 YES 2 NO		
AN:	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL		H YES NO		<b>X</b>				
SICI	EXAMINER? HOSPITA		OTHER:	me 5 Nesidence 6	Other /Sneciful				
PHYSICIAN: MEDIC	27. MANNER OF DEATH 28a. DA		28b. TIME OF 28c. II		d. DESCRIBE HOW IN	JURY OCCURED			
BY	Netural 5 Pending Investigation	ACE OF INJURY — At hom		YES 2 NO	4 1 0 0 4 7 10 11 10 11				
COMPLETED	3 Suicide 6 Could not be detarmined	liding, atc. (Specify)	e, term, street, tectory, on	Ca 26	f. LOCATION (Street ar City or Town, State)	nd Number or Hurel	Houte Number,		
PE	29a. CERTIFIER CERTIFYING PHYSICIAN: To the b	est ot my knowledge, deat	th occurred at the time, de	ta and place, and due to t	the cause(s) and mann	ner as stated.			
NO.	one) I MEDICAL EXAMINER: On the bear						(a) and manner as stated.		
BE (	294 SIGNATURE AND TITLE OF CERTIFIER	27	111	29L LICENSE NUMBER	20/9	29d, DATE SIGNE	D (Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	CAUSE OF DEATH (ITEM	27) (Type, Print)	80	1101	June	21. 1995		
	William Renner 32	222 St. Paul		ore, Marvla	and 21218				
	31. DATE FILED (Month, Day, Year) 32. REG	STRAR'S SIGNATURE							
	JUN 2 3 1995 Alacd	WOUNT MARKET	,						



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DIVISION OF VITAL RECORDS, P.O. BC

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flows after death. Page 6 may be retained by the hospital or attending physician.

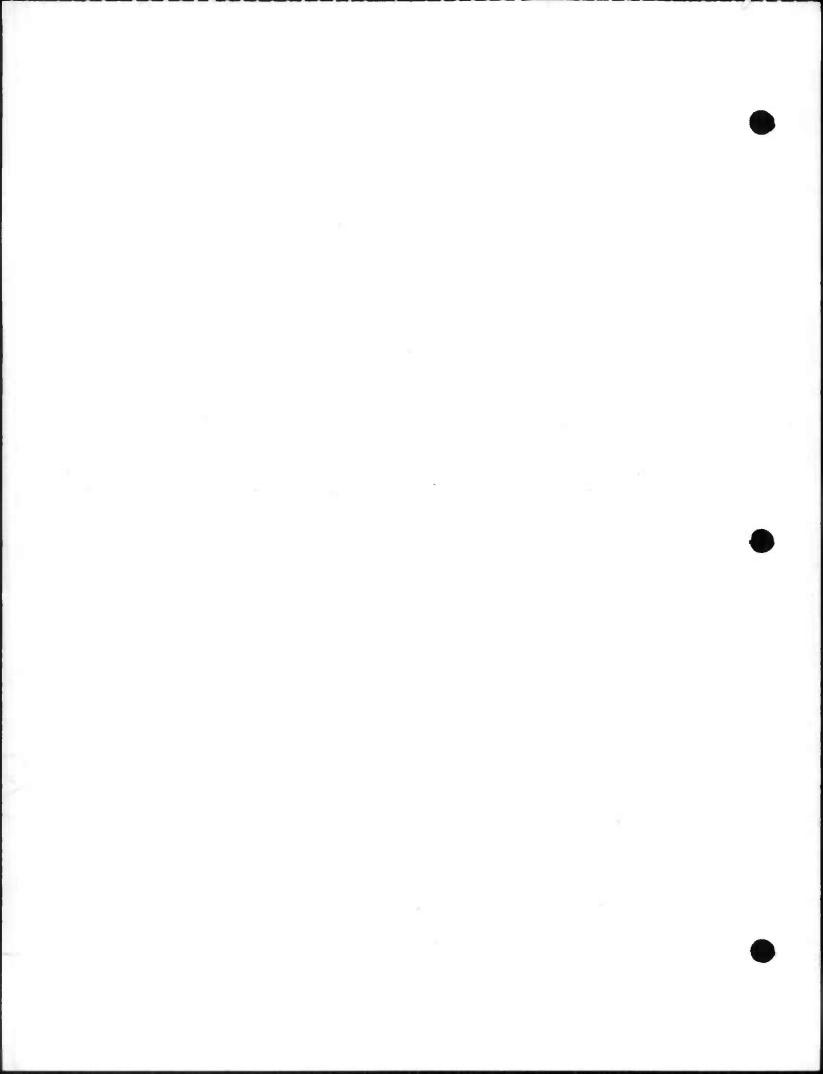
TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND	) / DEPARTA	MENT OF H	EALTH AND N	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Aliddle, Last)	W	Bro	WN	, ,	JUNE 2	1 1995	1 / for the	
	4. SOCIAL SECURITY NUMBER 215-46-7462	5. SEX 6. AGE (In yrs. 1 1 M 2 1 F 49		UNDER t YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) February	12,1948	British Maryland	
FOR	99. FACILITY NAME (If not institution, give structure) St. Joseph's Hospinessidence of decement		91	Tows	n LOCATION OF DE	9c. COUNTY OF DEATH Balto.			
DIRECTOR	10a. STATE 10b. COUNTY	alto.		own on Locat			10d, INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO		
FUNERAL	100. STREET AND NUMBER  137 Greenridge Ro	oad		101	ZIP CODE 21093	DOE 10g. CITIZEN OF WHAT CO			
BY FUN	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED MNO	If yes, spe	ENDENT OF HISPAN Icity Cuben, Mexicar 2 NO Specify	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	В	ACE — American Indian, llack, White, etc. pacify:  White	
COMPLETED	15. DECEDENT'S EDUCI (Specify only highest grade of Elementary/Secondary (0-12)	ATION 16a. College (1-4 or 5+)	DECEDENT'S USI (Give kind of work life. Do NOT use re HOME M	done during mo: tired.)	N st of working	16b. KIND OF BUS			
BE COM	17. FATHER'S NAME (First, Middle, Lest)	18. MOTHER'S NAM	ME (First, Middle, Maiden : ret Perki:						
TO B	Mr. Francis L.	Brown		DRESS (Street o		oute Number, City or Town	n, State, Zip Code)		
	20b. PLACE AND DATE of Disposition 3 Commenced from State commenced from State of Commenced from State								
1	22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson , Md. 21204							nc. 1204	
	23. PART I. Enter the diseases, or conshock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that coused the last only one cause on each I	al Book	Red	/	as cerdiac or respin		Approximate interval Between Onset and Daath	
ATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEQUENCE OF):						
AL	PART II. Other algnificant conditions	contributing to death but no	ot resulting in t	he Underlying	cause given in F	Part i. 24a. WAS AN / PERFORI	MED?	24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI				UNCERTAIN			DF DEATN? 1 YES 2 NO	
YSICI/	12 YES 2 NO	HOSPITAL: 1   Inpatient 2   Involupatient		THER:	5 Residence 6	B ☐ Other (Specify)			
ВУ РН	27. MANNES OF DEATH  1 Matural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	M 1 Y		28d. DESCRIBE NOW IN	JURY OCCURED		
	8 Could not be determined	28e. PLACE OF INJURY — At building, atc. (Specify)	home, farm, stree	t, factory, office		26f. LOCATION (Street e. City or Town, State)	net end Number or Rural Route Number, ate)		
COMPLETED		IAN: To the best of my knowledge,						ue(e) end manner ee stated.	
TO BE	296. SIGNATURE AND THE OF CERTLEIGH	10 pon	nelle	(Mu)	1) - 493	SS S	29d. DATE SIGN	D (Month, Day, Year)	
4	30 HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (I	11)-11	114/4	nleta	4.1/A1	Bytim	me md	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	9
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	EMOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
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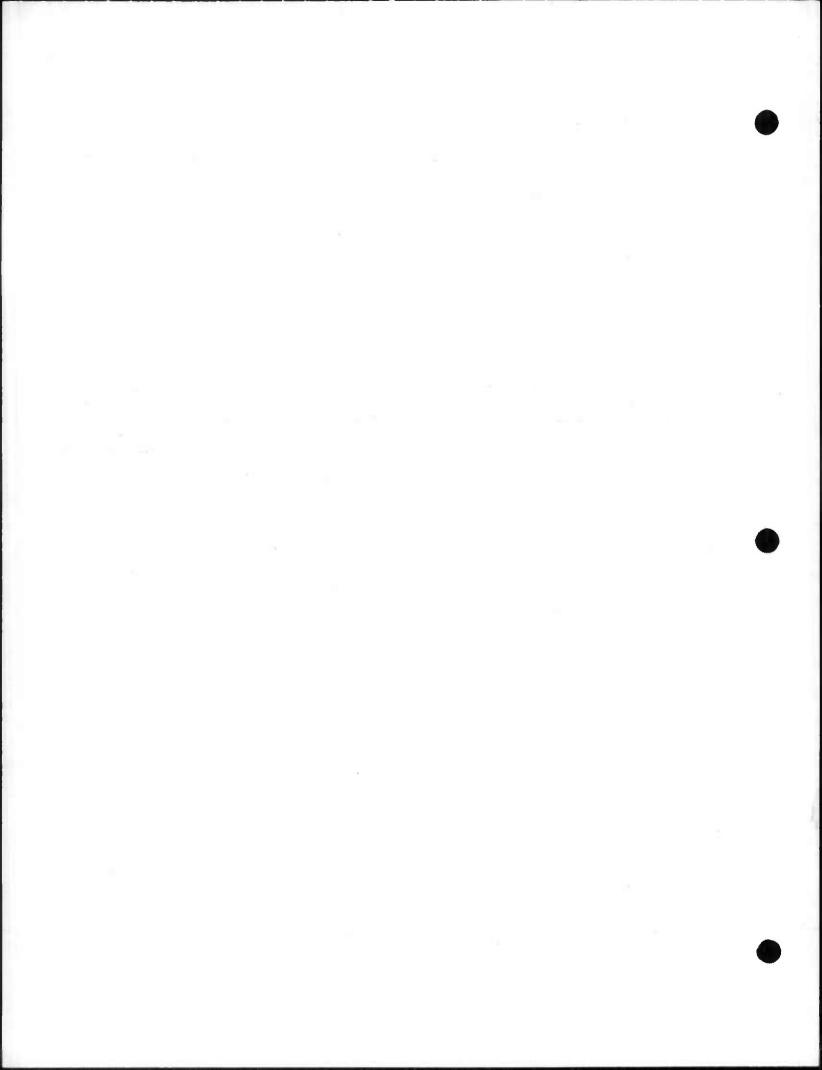
		1 - FOR STATE REGISTRAR	TATE OF MARYLA		RTMENT OF		MENTAL HYGIEN REG. NO	_			
		1. OECEDENT'S NAME (First, Middle, Last)	YARy (a	RRING	TON		2. DATE OF DEATH DON'TH TO	OTH 1999	3. TIME OF DEATH		
P		215-22-5385	M 2 XF	yrs. last birthday) 93 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-1-01	Co	RTHPLACE (State or Foreign unitry) N • C •		
1, 2, 3 should	RECTOR	96. FACILITY NAME (If not institution, give street of LEVINDALE NURSI) RESIDENCE OF DECEDENT				ALTIMORI		9c. COUNTY O	F DEATH		
nit. Pages	□	MD 106. COUNTY N/	A		Y, TOWN OR LOCA BALTIM	ORE CITY	Y		10d. INSIDE CITY LIMITS? VES 2 NO		
physician. burial-transit permit. Pages 1,	FUNERAL	5628 ARNHEM ROAL				OF. ZIP CODE 212(		U.S	• A •		
	B	1 Never Merried 2 Merried	WAS DECEOENT EVER IN L FORCES? 1 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, s	CENDENT OF HISPAN pecify Cuben, Mexical S ZOTANO Specify		S	ACE — American Indian, lack, White, etc.		
ital or attending of for use as the	LETED		eleted)	(Give kind of the life. Do NOT us	USUAL OCCUPATION or done during more retired.)  EWIFE	ON ost of working	18b. KIND OF BU	SINESS/INDUSTR	Y		
by the hospital be detached for at once.	E COMPLET	12 ] 17. FATHER'S NAME (First, Middle, Last) WILLIAM ALBERT JO	N/A L OHNSON	11003	EWIFE	18. MOTHER'S NAI	ME (First, Middle, Malden		SON		
y be retained age 5 should be notified	TO BE	190. INFORMANT'S NAME (Type/Print) ALEE CARRINGTON		19b. MAILING 5628	ARNHE	and Number or Rural R	Oute Number, City or Tow	n, State, Zip Code; MD •	21206		
e 6 mar rector, p	i.	20s. METHOD OF OISPOSITION 1 \[ \sum_{\text{Burlet}} 2  \text{Cremetion } 3  \text{Removal f} \] 4 \[  \text{Donation}   \text{Other (Specify)}.  21. BIGHATURE OF FUNERAL SERVICE LICENSE	rom State Cemet	ery, cremeroey of o		ME	6/24 GLI	CATION — City of EN BUR	NIE, MD.		
9 76 60		· Leverly	romari	te	1129		BETTS I	BALT	L HOME O,MD21213		
ted with cours after completely filled in by the ial, cremation, or removal cevent, the medical		23. PART I. Effect the disease, or companious, or heart fellure. List of iMMEDIAYE CAUSE (Final disease or condition resulting in death)	PUSSIBLE DUE TO (OR AS A C	h iina.			Leel inf		Approximate interval Between Onaat and Daath		
n certificate be executed and physician and com Hygiene prior to buriat, or other traumatic ex	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	OUE TO (OR AS A C	ONSEQUENCE OF	F): MMM		u'dent				
w requires that the death been signed by the atten or. of Health and Mental I Shows any injury, or	MEDICAL C	PART II. Other aignificant conditions con	ntributing to death but	not reaulting	in tha undariyin	g cause givan in i	Part i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
The law ate has b ate Dept.	PHYSICIAN:		SPITAL:	PLACE OF DEAT	S NO C						
PHYSICIAL this certification with the riked, or		27. MANNER OF OEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	4 Nursing Hon E OF 28c. IN. URY	JURY AT DRK? YES 2 NO	B Other (Specify) 28d. OESCRIBE HOW II	NJURY OCCURED			
DR ATTENDING DIRECTOR: After hours after death item 28 is mail	TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, a			281. LOCATION (Street a City or Town, State)	and Number or Rur	al Route Number,		
HOSPITAL DR A FUNERAL DIREC Within 72 hours	COMPLETED		(Check only Type Prysician: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and menner as stated.								
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 P IMPORTANT: If I	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	P	you.	an.	D448	BER -	29d. DATE SIGN	ED (Month, Day, Year) 42014 995		
4		30. NAME AND ADDRESS OF PERSON WHO COM SUNIL PROPERTY 31. DATE FILED (Month, Day, Year)	MPLETEO CAUSE OF BEATI 2 03 32. REGISTRAR'S SIGNATI	4 W1	Jelues	here as	re, Bu	Itime	Se ·		
			Devolute Ren						DHMN: 18 Rev 1/89		



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed with 1 - STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

												1120.110.	-		
		1. DECEDENT'S NAME (First,		OMBIGI							2. DATE O	F DEATH DA	Y	YEAR	3. TIME OF DEATH
		DIMICHE		OMPISI							JUNE	20	1	995	8:14 A M
		4. SOCIAL SECURITY NUME	177	5, SEX		rs. lest birthday)	IF UNDE	DAYS	HOURS	24 HRS.	7. DATE O (Month,	е вияти 21 1	010	8. BIRTH	PLACE (State or Foreign YOrk
Pin		216-20-044		1 M 2 F	83	3 YRS.						21 1	912	New	York
3 should	m	9s. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					EATH			
6	½	St. Agnes		a1			Ba	altin	more					NI	9
25	DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
2	=	Md.	Ba1t	imore		Ca	ton	svi1	1e					- 1	LIMITS?
ermi	4	100. STREET AND NUMBER						10	H. ZIP CODE	E			10g. CIT	ZEN OF V	THAT COUNTRY?
nsit p	ER	124 Herbe	rts Ru	n					212	28				USA	
burial-transit permit. Pages	FUNERAL	11. MARITAL STATUS		12. WAS DECEOEN			13					(Specify Yes	or No-	14. RACE	- American Indian,
T TA	ВУ	1 Never Married 2 3 Widowed 4 Divo		FORCES? 1 IF YES, GIVE W	AR OR DATE	s WWI]	:		pecify Cuba S 2 🙀 NO		n, Puarto Ri	can, atc.)			white atc.
as the				-											
USE as	TED	(Specify only	EDENT'S EDUC y highest grade	completed)	16	(Give kind of Me. Do NOT u	work done	during m	tON ost of workin	g	16b. i	CIND OF BUS	INESS/INC	DUSTRY	
D D	121	Elementary/Secondary (0	)-12)	Cottege 4-4 or 5	-)	Super					Ir	nterna	l Re	venu	e Service
detach once.	COMPLET	17. FATHER'S NAME (First, M	iddle, Last)				_	_	18 MOTA	ED'S NA	ME (Elent Mi	ddle, Maiden S	Cumanal		
at o	Ш	Anthony		Compisi						rian		Borzel	,	·i	
5 should be detached for notified at once.	00	19a. INFORMANT'S NAME (7)	ype/Print)	· · · · · · · · · · · · · · · · · · ·		19b. MAILING	ADDRES	SS (Street	and Number	or Rural F		r, City or Town			
5 si	5	Richard Com	pisi			511 Cc								, 0000)	
page if <b>be</b>		20a. METHOD OF DISPOSITI	ION			ACE AND DATE					OATE	20c. LOC	ATION —	City or To	wn, Stata
funeral director, page xaminer must be		12 Burial 2   Cremetion 3   Removal from State   Commetted, Cremetory or Chief (Specify)   Commetted of Com													
ral di		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE			22		NO ADDRES						
e funeral dir I. examiner	!	► KW	1 4	$\sim \times$	-		-1	Ruc. 105	k Tow O Yor	son k Ro	F.H. I. Tov	vson M	id. 2	1204	
n by the removal.		23. PART I. Enter the di	seases, or d	omplications tha	t caused th	e death. Do i	not ente								Approximate
DOE		shock, or he IMMEDIATE CAUSE (Fin	asrt laliure. I	lat only one cau	se on each	line.						о тоори	atory or		Interval Between Onset and Dasth
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ending phy Hygiene p or other	E	that initiated events resulting in death) LAS		DUE TO	(OR AS A CO	INSEQUENCE OF	F):								
tal H	CER			),											
led by the att th and Menta any Injury,		PART II. Other significs	nt conditions	contributing to	death but r	not reaulting	in the u	nderlyln	g cause g	iven in i	Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS
signed by the Health and Jws any In	DICAL	Diabet	tes M	celli tu	2						PERFORMED?  1 □ YES 2 ⋈ NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
Sign Heal	Ä	Renal	Failu	and the							_		@ NO		OF DEATH? 1 ☐ YES 2 52 NO
60 D 45	AN:	DID TOBACCO U			USE OF I	DEATH YE	s 🗆	NO [	UNC	ERTAIN	1 🛭			İ	
cate has State De Item 2	S	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL		26.	PLACE OF OEA									
certificate has be the State Dept. d, or Item 23 s	PHYSICI	1 TES 2 NO		HOSPITAL:	ER/Outpetle	nt 3 X DOA	OTHE		ne 5 🗆 Re	sidenca	6 Other (	Specify)			
this ce with th	H	27. MANNER OF DEATH	200000	26a. DATE OF (Month, Di		28b. TIM	E OF URY		JURY AT		26d. DESC	RIBE HOW IN	JURY OCC	CUREO	
After this death with smarked	B		Pending Investigation				М		YES 2	NO	_				
after de 28 Is	0		Could not be	28s. PLACE Of building,	F INJURY I atc. (Specify)	At home, farm, a	street, fac	ctory, offic	en .		28f. LOCAT City or	tON (Street at Town, State)	nd Number	or Rural A	oute Number,
	<b>L</b>														
7 C =	COMPL			CTAN: To the best of											
FUNERAL within 72 STANT: If	ŏ	MEDI	CAL EXAMINER	t: On the basis of a	amination an	d/or investigation	n, in my	opinion, d	death occur	ed at the t	time, data a	nd place, and	dua to th	a cause(s)	and manner as stated.
HE FL	w	296, SIGNATORE AND TITLE	OF CERTIFIED		,		-		29c. LfCE	NSE NUM	BER		29d. DATI	SIGNED	(Month, Day, Year)
TO THE FUNERA De filed within 7 IMPORTANT:	0	Vauc	1	Maha	ul	ces)	_		D:	359	572		1	ine	20,1995
	F	30. NAME AND ADDRESS OF	BERBON WHO	COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type,	Print)				-	0			
NXV		David	٧٠.	Kahau 32. REGISTRA 14 N 2 3 15	, u	ND.	5+	Ag	nes	40	1920	tal.	Bal	+, m	P
0.,		31. DATE FILED (Month, Day, )	Ybar)	32. REGISTRA	SIGNATU	The day	alser	Kerd	4			_			
		June 20,1	1495	010	0										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGI					
	1. DECEDENT'S NAME (First, Middle, Last)				527111	2. DATE OF DEAT	Н		3. TIME OF DEATH		
- 1	MARVIN L		DURNER			JÜNE	79 19	95	12:05P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea	r)	8. BIRTH	PLACE (State or Foreign		
	216-10-2836		31 YRS.			MARCH 11	1914	MAR	YLAND		
DIRECTOR	9a. FACILITY NAME (II not institution, give structure)  ANNE ARUNDEL GENERAL RESIDENCE OF DECEMENT	a received and a second	1		TOWN OR LOCATION OF DEATH  NAPOLIS  ANNE ARUNDEL						
E I	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION		10d. INSIDE CITY				
	MARYLAND ANNE	ROWNSVI	LLE			1 TYES 2 NO					
FUNERAL	10e. STREET AND NUMBER			10	H. ZIP CODE		17.2		HAT COUNTRY?		
W	1599 CROWNSVILLE	ROAD  12. WAS DECEDENT EVER I			21032		USA				
BY FU	1 Never Married 2 X Married 3 Widowed 4 Divorced		YES 2 NO If yes, specify Cubert, Men			lexican, Puerto Rican, atc.)			ACE — American Indien, ack, White, etc.		
요	15. DECEDENT'S EDUCA		16a. DECEDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF	BUSINESS/INDU	JSTRY	MILLIE		
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use		ost of working						
필	8th		BUTCHER	₹		GRO	CER	CER			
	17. FATHER'S NAME (First, Middle, Last)		-			ME (First, Middle, Ma					
H H	ELDREAD MILT  190. INFORMANT'S NAME (Type/Print)	TON DURN			ANNI				CHCOMB		
2	MARIE ANGEL DURN	MED				ROUTE Number, City or			RYLAND 21032		
	20a. METHOD OF DISPOSITION	201	PLACEANDDATEO				LOCATION — C	_			
	1 🖟 Burial 2 🗆 Cremation 3 🗆 Remove 4 🗆 Donation 5 🗀 Other (Specify)	val from Stats cen	MEAROWRID	GE CEME		1			MARYLAND		
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	ND ADDRESS OF FA				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	HARVY S	tallings Jr.						MAR'	YLAND 21122		
	23. PART I. Entar the diseases, or co shock, or heart failure. Li	omplications that caused	the death. Do no	t anter the me	ode of dying, suc	th as cardiac or re	papiratory arre	est,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	CARCLED		100	Set				Onset and Death		
	resulting in death)  a										
z	Sequentially flat conditions, a As proature / Memmai										
CATION	if any, leading to immediate cause. Enter UNDERLYING	A BUT TOMOR AS	CONSEQUENCE OF	. (-	00				10		
2	CAUSE (Disease or Injury that initiated events	DUE TO COR AL A	CONSEQUENCE OF		GAS	•					
RTIF	resulting in deeth) LAST	U									
S	PART II Other elgofficent conditions	anatribution to doub b									
<b>8</b>	PART II. Other significant conditions	contributing to death b	ut not resulting in	the underlyin	g ceuse given in	Part I. 24e. WAS PER	FORMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDIC						1 YES	5 2 NO		COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTRI	IBUTE TO CAUSE C	E DEATH YES		UNCERTAI	NM	(		1 YES 2 NO		
X	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH					1			
	1 YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence	8 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME		JURY AT	28d. DESCRIBE HO	W INJURY OCCI	URED			
<b>₩</b>	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	At home, farm, str city)	eet, factory, offic	28	28f. LOCATION (Str. City or Town, St	eet and Number o	or Rural A	oute Number,		
COMPLET	29a. CERTIFIER	Asia Taraha bankari atau da atau									
ME		On the best of my know							and manner as eleted		
	296. SIGNATURE AND TITLE OF CENTREES.			(Month, Day, Year)							
BE	Jail	Jeula	sten	MUS	29c, LICENSE NUI	2194	<b>&gt;</b> /	12/1	9/95		
2 ▮	30. HAME AND ABBRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F	rint)	1.0	2. (6:		4	10		
	200 Miagel	y HVE,	Hnnas	blis	MU à	1401	Jack	Lich	tenstein MD		
	JUNZ 3 1995	The state of the s	MERE					•			
ı (i	JUILO 9 1999										

PARTLAND ANGE

1599 CROWNSVILLE ROAD

8th

ELDREAD MILTON DURNEF

\*E ANGEL DURNER

134

X

Stallings Dr.

TO BE COMPLETED BY FUNERAL DIRECTOR

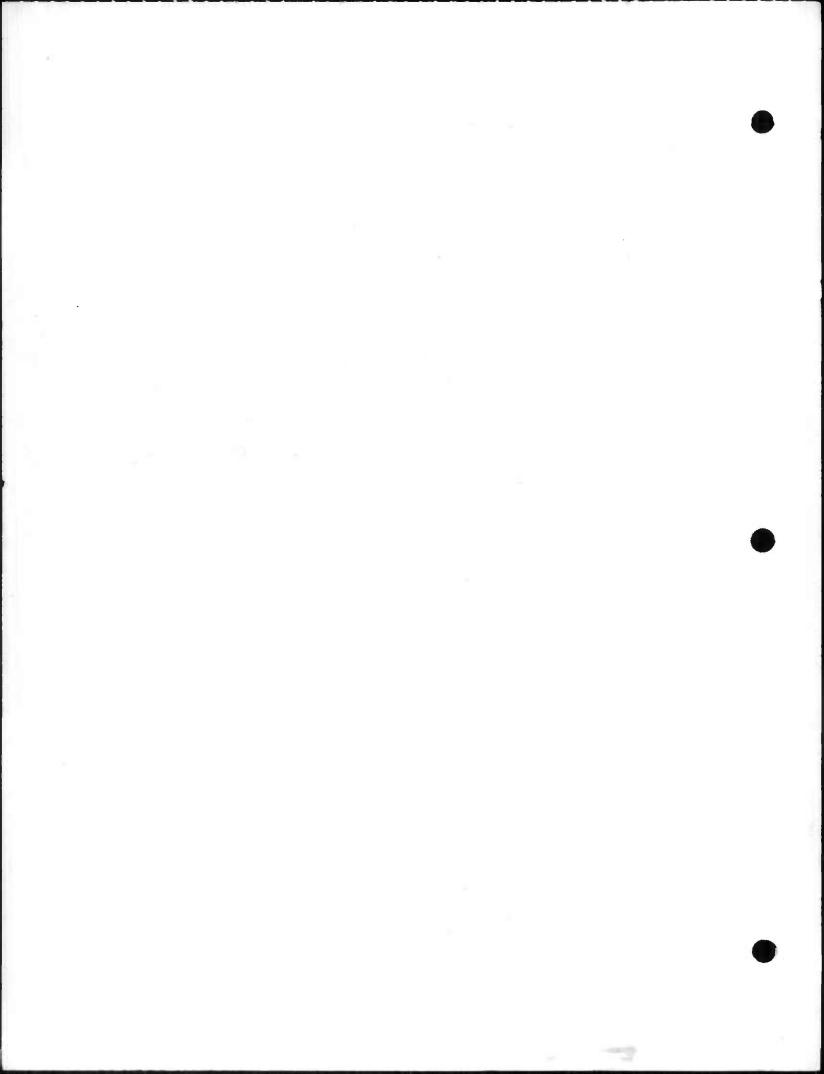
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Mours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

REGISTRAR	CERTIFICA	ATE OF DEATH	REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)	Wiffin Da	tcher,	2. DATE OF DEATH	15 12 AM
219-10-3473	M 2 F 69 YAS. MON	UNDER 1 YEAR IF UNDER 24 HRS.  ITHE DAYS HOURS MIN.	Sept. 21,1925	BIRTHPLACE (State or Foreign Couptry)
99. FACILITY NAME (If not institution, give street LEVINGALE RESIDENCE OF DECEDENT	lursing Home	Baltimo	ATH Sc. COUNT	OF DEATH
Maryland 10b. COUNTY	VA HVA	TSVILLE		10d. INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBER 6700 Belcy 11. MARITAL STATUS	est Rd.	101. ZIP CODE 2078	2	EN OF WHAT COUNTRY?
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 VES 2 NO	13. WAS DECENDENT OF HISPAN It yes, specify Cuben, Mexica 1 YES 2 WNO Specify	n, Puerto Rican, etc.)	4. RACE — American Indian, Black, White, atc.  Specify: Black
15. DECEDENT'S EDUCAT (Specify only highest grade co. Elementary/Secondary (0-12)		done during most of working	166. KIND OF BUSINESS/INDU	STRY MOLALED
James Mat	Thew Datche	er Dor	ME (First, Middle, Meiden Surneme)	n
199. INFORMANT'S NAME Type/Print) He e D 1 209. METHOD OF DISPOSITION	her 16700:	Bel Crest	Rd, Hyattsi	sille, Md. 20782
1   Burisi 2   Cremation 3   Remova 4   Donation 5   Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	Garri		OATE 200 LOCATION - CH	gs Mills, Md.
23. PART L'Enter the diseases, or con	I, Thus  Inplications that coused the death. Do not e	2222 W.	Monte A18	2/2/6
shock, or heert failure. Lie immediate Cause (Final disease or condition resulting in death)	the only one cause on each line.  Authorized Authorized Office (OR AS A CONSEQUENCE OF):	id theag	i as cardiec or reapiratory arrea	Approximate interval Batween Onset and Daeth
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):	in		
PART II. Other algnificant conditions of	contributing to deeth but not resulting in th	e underlying ceuse given in	Part I. 24a. Was an Autopsy PERFORMED?  1  YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DEATH YES [	□ NO □ UNCERTAIN		1 TES 2 NO
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (C			
	Inpetient 2 ER/Outpetient 3 DOA 4	Nursing Home 5 - Residence		
1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY	28c, INJURY AT WORK?  M 1 YES 2 NO	28d. OEŞCRIBE HOW INJURY OCCU	RED
3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At home, tarm, street building, atc. (Specify)	t, factory, offica	28t. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
	N: To the best of my knowledge, death occurred at On the basis of examination and/or investigation, in			
296 AIGNATURE AND TITLE OF CERTIFIER	physian	D448	BER 29d. DATE S	SIGNED (Month, Day, Year)
30. NAME AND ADDITESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print TAWI 2434	"Be Inde	re ave Bo	Utimose-
111N 2 2 1995 Julia	China Carlotte			



BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after clearly with the State pert of Health and Memtal Hydiana point to hurtal command on comparation or named.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be find within 72 hours after death with the State Dear of basin and Mental Hydings prior to burial command in command.	

STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CI	FRTIFICATE	OF DEAT	TH.		DEC NO

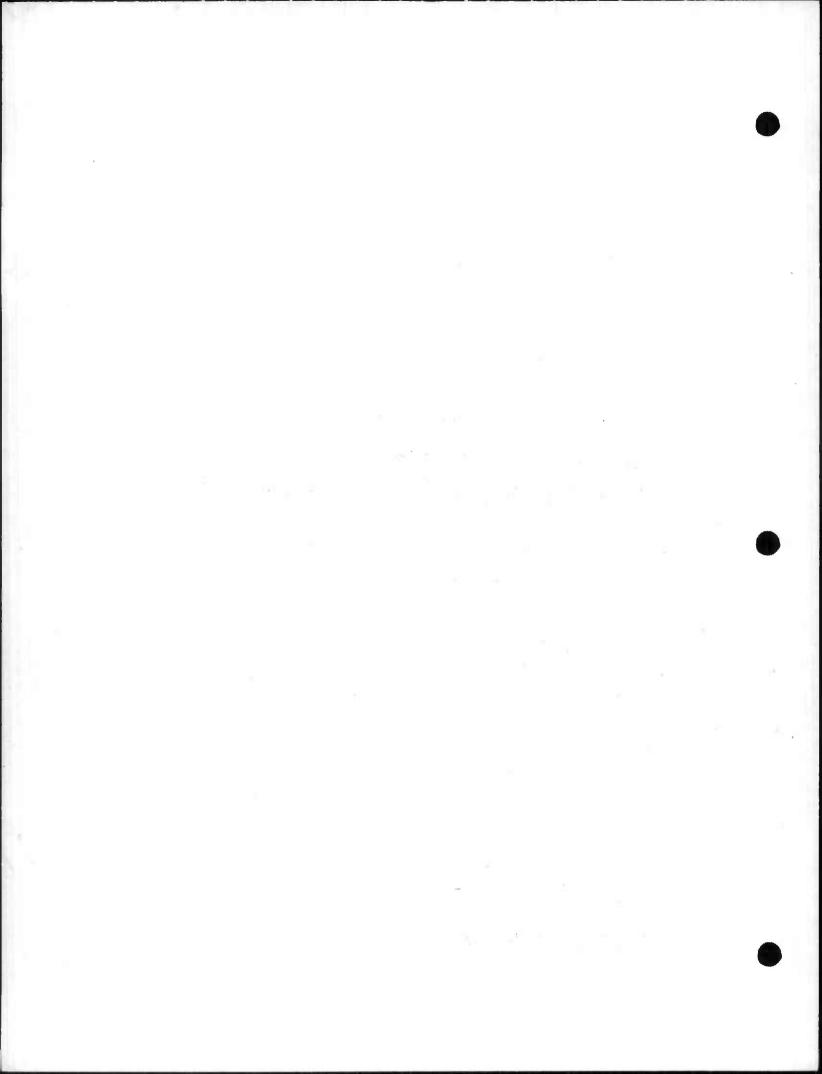
	1 - STATE REGISTRAR	STATE OF MARY	AND / DEPARTM	MENT OF H	EALTH AND	MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH			3. TIME OF DEAT	н	
	JOHN		DANZA			6	2		YEAR 9.5	1:30	a M	
	The state of the state of		6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UN MONTHS DAYS HOUR			7. DATE (Mon	OF BIRTH th, Day, Year)	1	Country	PLACE (State or For	reign	
	213 20 2133		05			7-	22-29					
۳ ا	9a. FACILITY NAME (If not institution, give stree				OR LOCATION OF E	SEATH SC. COUNTY OF DEATH			EATH			
6	205 Ridgefiel	d Rd.		Luther	cville			Balt	time	ore		
HE	10a, STATE 10b, COUNTY		10c. CITY, T	OWN OR LOCAT					10d, INSIDE CITY			
5	Maryland Balt:	imore	Luth	ervill	.e					LIMITS?	NO	
FUNERAL DIRECTOR	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?		
Ÿ	205 Ridgefield				21093	U.S.A						
	11. MARITAL STATUS  1 Never Merried 2 Married	2. WAS DECEDENT EVER I	2 NO	13. WAS DEC	ENDENT OF HISPA ecify Cuben, Mexic	NIC ORIGI	N? (Specify Yes Rican, etc.)	or No- 1	4. RACE Black	— American India, White, atc.	ın,	
à	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	ecify:				Specify: White				
	15. DECEDENT'S EDUCAT (Specify only highest grade col		18e. DECEDENT'S US	UAL OCCUPATION	ON	186	. KIND OF BUS	INESS/INDU		1100		
Ξ.		College (1-4 or 5+)	(Give kind of work life. Do NOT use re									
COMPLETED		5+yrs	Insuranc	ce Spe	cialis	t	Insu	urance				
3	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First,	Middle, Maiden	Surname)				
BE	Angelo	Danza			Anna			assi				
임	Mary Jane Danza	in. INFORMANT'S NAME (Type/Print)  19b. MAILING ADD										
	20a. METHOD OF DISPOSITION	To The state of th									93	
208. METHOD OF DISPOSITION  1 X Buriel 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  209. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  Gardens of Faith  6-23 Overlea, Mo												
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	Jardens C		D ADDRESS OF F	ACILITY	310Ve	rlea	M	d.		
	11/11				Towson							
⊣	23. PART i. Enter the diseases, or con	policetions that cause	d the death. Do not	11050	York I	Rd.	Towso	a. Mc		21204 Approxima		
23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heert failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. Metastatic colon cancer  DIFF TO (OR AS A COMPROVISIONE OF)									interval Be Onset and	Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE DF):  c. DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL (	PART II. Other algorificant conditions of	ontributing to deeth b	out not resulting in t	he underlying	ceuse given in	Part i.	24a. WAS AN / PERFORI	MED?		WERE AUTOPSY FINANAILABLE PRIOR TO COMPLETION OF COOP DEATH?	TO AUSE	
	DID TOBACCO USE CONTRIB	UTE TO CAUSE C	F DEATH YES	□ NO □	UNCERTA!	N 🗆						
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OCRITAL	26. PLACE OF DEATH									
2		OSPITAL:  Inpetient 2 ER/Out	patient 3 DOA 4	THER:  Nursing Home	5 Pasidence	6 🗆 Othe	r (Specify)					
2	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O			28d. DE	SCRIBE HOW IN	JURY OCCU	RED			
	2 Accident Investigation	M 1 YES 2 NO										
וייי	3 Suicide 8 Could not be 4 Homicide determined	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						ffice 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLEIED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: C									end menner as sta	eted.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	2 100	/		29c. LICENSE NU	MBER		29d. DATE S	GIGNED (	(Month, Day, Year)		
		Bull le	ar, no		D16	587		16	/2/	5/95		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH STEM 27) (7/po, Pro	10						1,0		
	Dr. Paul Chang	Good S	amaritan	Profe	essiona	ıl Rı	ıildir	na Ra	1+:	more	Мd	
	31. DATEJUN 121. 37. 1995 Ju	A PHIMISH	THE M					.y. 110			211.1	

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TICION OF ALLAC DECORDS, P.O. BOA 50/50	R ATTENDING PHYSICIAN: The
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH	

	1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF			IYGIENE BEG. NO.				
	1. DECEDENT'S NAME (First, Middle,	Last)	OLITTI	TOATE OF	DEATH	2. DATE OF			3. TIME OF DEATH		
	THELMA M. EANO	GLEHEART				June	1.8	1995			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I	BIRTH	8. BIRTN	IPLACE (State or Foreign		
	107-14-8930	Apr. 2	onth, Day, Year) Country)  Country)  NY								
~	9a. FACILITY NAME (If not institution,		1	1	OR LOCATION OF E	DEATN	9c. (	COUNTY OF D			
DIRECTOR	RESIDENCE OF DECEDEN	General Hospit	nbia			Howa	rd				
EC.		OUNTY	TION		10d. INSIDE CITY						
	MD Ho	oward		Columbia					LIMITS? 1 YES 2 NO		
₹ I	10e. STREET AND NUMBER			10	f. ZIP COOE		10g.		VHAT COUNTRY?		
FUNERAL		ens Forest Road			21045			USA			
	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 K NO	If yes, s	CENDENT OF HISPA pecify Cuban, Maxic	an, Puerto Ricai		E — American Indian, c, White, etc.			
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗆 YE	S 2 X NO Spec	lly:		Speci	Black		
COMPLETED	15. DECEDENT'S (Specify only highest	3 EDUCATION		S USUAL OCCUPATE		16b. KIN	ID OF BUSINESS	/INDUSTRY			
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT t	ise retired.)	ost or working		3.41 =:				
MP	10 17. FATHER'S NAME (First, Middle, Let	None	Nurse's	Alde			lth Fie				
5	Unknown	3()				AME (First, Middl Wilkins	le, Maiden Surnam	10)			
B	19a. INFORMANT'S NAME (Type/Print)	)	19b. MAILIN	D AGGRESS /Street	1			Tin Code)			
2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILINO AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Florence Eangleheart (Daughter)  5664-127 Stevens Forest Rd. Columbia, MD 21045										
	20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 N	201	PLACE AND DATE	OF DISPOSITION /N	eme of	CATE	20c LOCATION	- City or To	we day.		
	4 Donation 5 Other (Specify)	Ca	Lverton	National	Cem. 2	2, 1995	Calver	cton,	NY		
	21. SIGNATURE OF TURE RAL SERVI	CE LICENSEE	1	22. NAME A	ND ADDRESS OF F	ACILITY					
	· K.CO	Wiske	4	5555	win Kno	lls Rd	Columbi	ia, MD	21045		
	23. PART I. Enter the diseeses shock, or heert fall	, or complications that cauch	d Me death. Do	not enter the mo	ode of dying, su	ch aa cardiec	or reaplratory	arreat,	Approximate Interval Between		
ŀ	IMMEDIATE CAUSE (Finel										
	resulting in death) - ACUTE MYOCARDIAL INFARCTION										
,	DUE TO (OR AS A CONSEQUENCE OF):  ASTHMA EXACERBATION  30 minutes										
<u>e</u>	Sequentially list conditions, If any, leading to immediate  OUE TO (OR AS A CONSEQUENCE OF):										
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	c									
E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE C	OF):							
CERTIFICATION	d										
	PART II. Other algolficent cond	ditiona contributing to death b	out not reaulting	in the underlyin	g ceuse given ir	Part I. 24s	. WAS AN AUTOP PERFORMED?	SY 24b.	WERE AUTOPSY FINGINGS AVAILABLE PRIOR TO		
MEDICAL	Hypertension					10	TES 2 NO	.	COMPLETION OF CAUSE OF DEATH?		
¥		litus (Non-Insu							1 TES 2 NO		
AN	DID TOBACCO USE CO	ONTRIBUTE TO CAUSE O			UNCERTAI	N 🖾					
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:		d_ = 7					
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIR	AE OF 28c. IN.	00 5 Residence		ecily) BE NOW INJURY	OCCURED			
ВУ Р	1 Netural 5 Pending 2 Accident Investige		IN	JURY WO	PRK? YES 2 NO				- 1		
	3 Suicide 6 Could no	28a. PLACE OF INJURY	— At home, farm,	street, factory, offic		28f. LOCATIO City or To	N (Street and Nun	nber or Rural R	oute Number,		
COMPLETE	4 Homicide determin	ed	,,			City of 10	wn, steley				
4	(Check only one)	PHYSICIAN: To the best of my know	ledge, death occur	red at the time, date	and place, and du	e to the cause(a	) end manner as	stated.			
ξ.	2 MEOICAL EXA	AMINER: On the basis of examination	n and/or investigati	on, in my opinion, o	leath occured at the	time, data and	place, and dua t	o the ceuse(a)	and menner as stated.		
29b. SIGNATURE OF CERTIFIER  29c. LICENSE NUMBER									(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSO	N WNO COMPLETES CALLES OF ST	ATM STEM OF C	Polant	D4478	2	P.	June 1	8, 1995		
	Jerry Ann Hunt			rth DRive	Colum	hia MT	210/5				
	31. DATE FILED (Month Day Year)	32. REGISTRAR'S SIGN	ATURE	CH DAIN	, ooruli	ora, III	, 21043				
	JUN 2 3 1995	Table d'Evelor Ren	fall								
		,									



3. TIME OF DEATH 350 P. W

8. BIRTHPLACE (State or Foreign Country)

Maryland

21204

REG. NO.

1938

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year)

June

FOR STATE REGISTRAR

MELVYN

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

ELSWORTH

DR. KENDALL FAULKNER

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DIVISION	
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1 /	217-34-9139	1 LXM 2 L F	56	YRS.				August 4,	1938	3 Mar	ryland	
-	90. FACILITY NAME (If not institution, give	e street end number)			9b. CITY, TO	WN OR LOCATI	ON OF DEAT	Н	9c. COUN	TY OF DEAT	Н	
ECTOR	Stella Maris				OT	vson			Ba]	Ltimor	re	
<u> </u>	10e. STATE 10b. COUN	NTY		10c. CIT	Y, TOWN OR I	OCATION				10	d. INSIDE CITY	
DIR.		altimore			White Marsh					1 VES 2 NO		
RA	100. STREET AND NUMBER 9619 Pulask					101. ZIP COD					T COUNTRY?	
FUNERAL	11. MARITAL STATUS	i Highway				212				J.S.A.		
B	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, CITYE WAS 195	XYES 2	NO If yes, specify Cuben, Mexicon, Puerto Ricen, etc.)						14. RACE — Black, W Specify:	American Indian, hite, etc. White	
윤	15. DECEDENT'S Et (Specify only highest gra			DECEDENT'S (Give kind of w	vork done duri	PATION of most of world	na	16b. KIND OF BUS	SINESS/INDU	JSTRY		
COMPLET	12 yrs.	College (1-4 or 5+)		(Give kind of work done during most of working life. Do NOT use retired.)  Owner /Self Employed Motel								
NO.	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NAME	(First, Middle, Maiden	Surname)			
L to a	George	Engle					Bland	che Ed	wards	5		
TO BI	19e. INFORMANT'S NAME (Type/Print)		7	19b. MAILINO	ADDRESS (S	reet and Number	r or Rural Rout	e Number, City or Town	n, State, Zip (	Code)		
-	Pearl L. Engle Same as #10											
	20a, METHOD OF DISPOSITION 1 DBurlel 2 Cremation 3 Re	emoval from State	20b. PLACE	E AND DATE O	POSPOSITION	N (Name of	_			ity or Town,		
	4 Donetion 8 Other (Specify)	1	Dula	ney V	_	Mem. G			imoni	um, M	laryland	
1 1	21. SIGNATURE OF PUREMAL BERNICE	LICENSSE	/ -		22. NA	ME AND ADDRE	SS OF FACILI	TY		105	0 York R	
	· Carl	1. / and	al		Ruc	k Tows	on Fur	neral Hom	e, In			
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b	OR AS A CONSI	SEQUENCE OF	ገ): ገ):						18 mos	
#		d										
MEDICAL C	PART II. Other significant conditions C	ons contributing to d	death but not	t resulting I	n the unde	lying Couse (	given in Par	1 L 24s. WAS AN PERFOR	MED?	AM CO	RE AUTOPSY FINDING ILLABLE PRIORI TO MPLETION OF CAUSE DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN NO								] 123 2 [] 110			
YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ACE OF DEAT	H (Check only							
YSIC	1 VES NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	Home 5 🗆 Re	eldence 8 2	Other (Specify)	Hospi	ce		
BY PHY	27. MANNER OF DEATH  1 Naturel 5 Pending 2 Accident Investigation	28e. DATE OF II (Month, Day		28b. TIME	E OF 28-	WORK?	28	d. DESCRIBE HOW II				
TED	3 Suicide 6 Could not b 4 Homicide determined	28e. PLACE OF	INJURY — At I Hc. (Specify)	home, farm, s	treet, fectory,	office	28	f. LOCATION (Street e City or Town, State)	nd Number o	or Rural Route	Number,	
COMPLE		YSICIAN: To the beat of m									d manner ee stated,	
	294. SIGNATURE AND TITLE OF CERTIF	IER					ENSE NUMBE		29d. DATE			

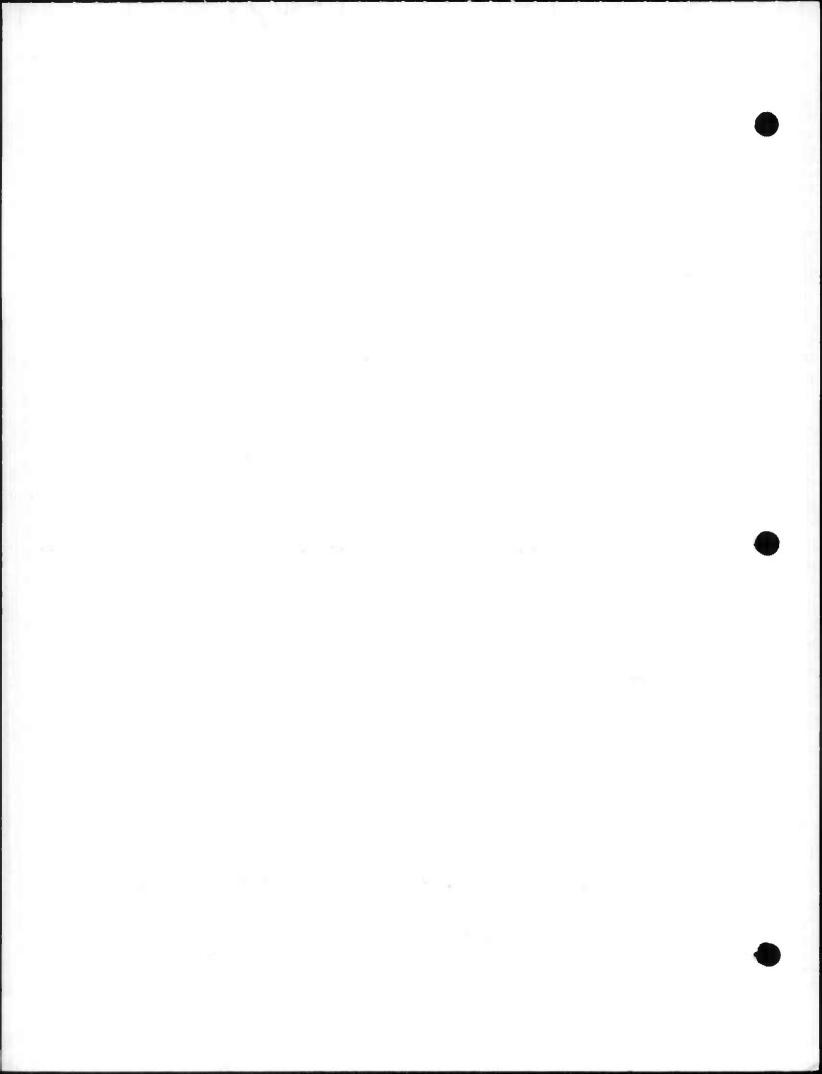
32 REDISTRATES SIGNATURE

**ENGLE** 

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 

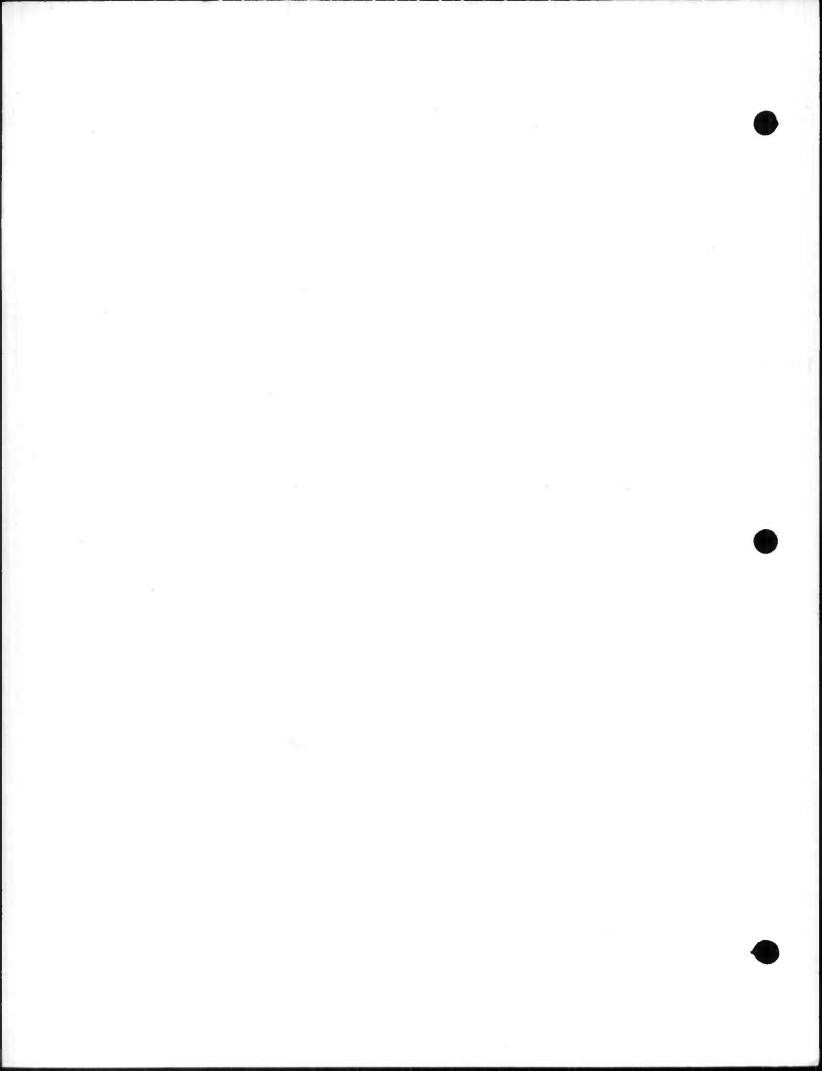
2300 DULANEY VALLEY RD., TOWSON, MD

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.



BALTIMORE, MARYLAND 21215-0020	Nurs after death, Page 6 may be retained by the hospital or attending physician.	in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal.	nedical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	ND / DEPARTN CERTIFIC			MENTAL	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH					
	Carolyn Elizabeth GIBSON				June 22,			1995	3:00A	м	
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	OF BIRTH Day, Year)	8. B	IRTHPLACE (State or Foreign	n	
	219-16-3189 1 - M 2 M F 70 YRS. MONTHS DAYS HOURS								ltimore, MD		
~	Sa. FACILITY NAME (If not institution, give		96		R LOCATION OF D			9c. COUNTY C			
5	6509 Eastern Parkway 21214 Baltimore N/A										
EC									10d. INSIDE CITY		
DIRECTOR	Maryland N/A Baltimore					LIMITS?					
						. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL	6509 Eastern Parl	kway		2	21214-140	06		U.S.	Α.		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		ENDENT OF HISPA			or No- 14. F	IACE — American Indian, Black, White, atc.	$\neg$	
BY	1 Never Married 2 Married   FORCES? 1 YES 2 (A) NO   IF YES, GIVE WAR OR DATES				2 NO Specific		Specify:				
							nite				
1	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done iffer on Nort use retired) (Give kind of work done iffer on Nort use retired) (Februaritant's programment (D.13)				CCUPATION during most of working  16b. KIND OF BUSINESS/INDUSTRY						
COMPLETED	College (1-6 0/ 5+)					1					
<b>∑</b>	17. FATHER'S NAME (First, Middle, Lest)			or	18. MOTHER'S NAME (First, Middle, Maiden Surname)						
ш	Charles Joseph 1	Belzner								- 1	
0	19a. INFORMANT'S NAME (Type/Print)				Flizabeth Marie Heneka Teel and Number or Rural Route Number, City or Town, State, Zip Code)						
2	Wesley V. Gibson	n	6509 Eas	stern F	Parkway l	Balti	more,	MD. 212	214	_	
	20a. METHOD OF DISPOSITION		PLACE AND DATE OF O		ma of	DATE	20c. LOC	CATION — City o	r Town, Stata		
	4 Donation 5 Other (Specify)	Greenmount Cemerery 0//4/91 ballimore, Maryland									
	21. SIGNATURE OF FUNEYAL SERVICE LIGENSEE  22. NAME AND ADDRESS OF FACILITY DIPPEL FUNERAL HOME, IN.										
	I John y	- Dahal	(	7110	Belair 1				Maryland 21		
MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (de As a consequence of):  DUE TO (or As a consequence of):  DUE TO (o										
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED MEDICAL EXAMINER?	25. WAS CASE REFERRED MEDICAL 26. PLACE OF DEATH (Check only one)									
2	1 TES 2 THO	HOSPITAL: 1   Inpatient 2   ER/Outpi	itlent 3 DOA 4	THER:  Nursing Hom-	Residence	8 🗆 Other	(Specify)				
5	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. INJURY AT WORK?			28d. DESCRIBE HOW INJURY OCCURED					
2	1 V Natural 5 Pending 2 Accident Investigation	1 Netural 5 Pending									
9	3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)					28t. LOCATION (Street end Number or Rural Route Number, City or Yown, Stete)					
2	29s. CERTIFIER (Check only  CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
COMPLE		one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
2	296. BIGMATURE AND TITLE OF DESTITION 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. 1) 296. LICENSE NUMBER 29							NED (Month, Day, Year) - 22 - 95	$\dashv$		
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prin	()		,		0	スター イン		
	John C. Downs.	John C. Dovns, M.D. 7505 Osler Drive /Suite505 Towson, Maryland 21204									
	31. DATE FILED (2001) 201995	MANUAL SIGNA	TURE					-			



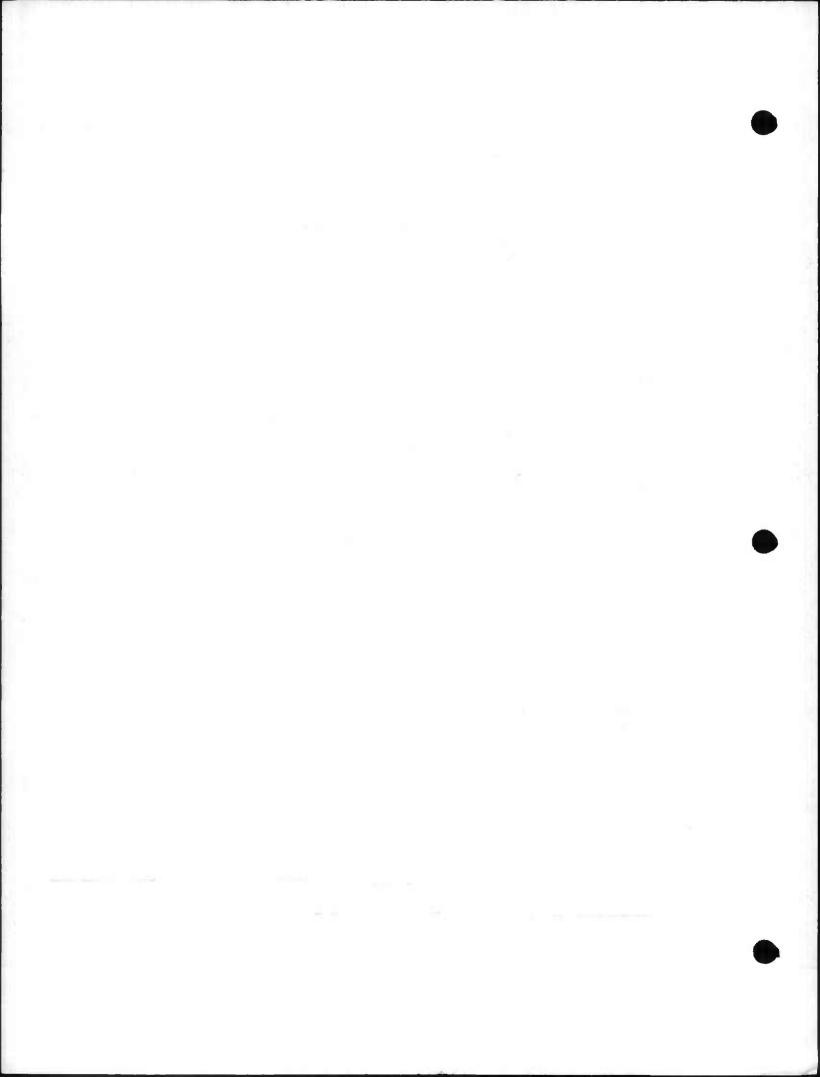
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the foath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

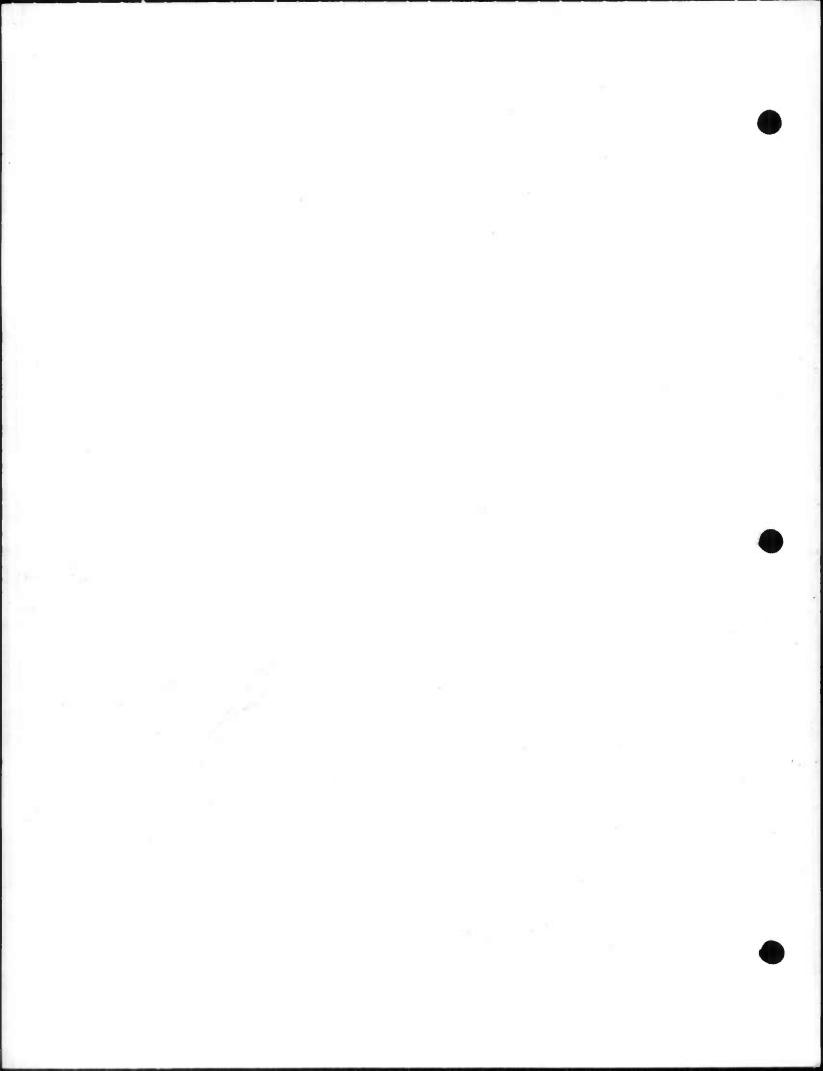
	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTME			MENTAI	HYGIENE			
	1. DECEDENT'S NAME (First, Middle, Last)	ley				2. DATE MONTH	OF DEATH DAY	1, 1995	3. TIME OF DEATH 5:42PM M	
	216-38-7314	1 M 2 BF 52 YRS. MONTHS DAYS HOURS ME			10 211	s. 7. DATE OF BIRTH (Morth, Day, Year) 9. BIRTHPLACE (State or Foreign Country) MD				
TOR	9a. FACILITY NAME (If not institution, give street and number)  MERCY HOSPITAL CENTER  BALTIMORE  N/A  RESIDENCE OF DECEDENT									
DIRECTOR	10e. STATE 10b. COUNTY MD N/A		BALTIMORE CITY					10d. INSIDE CITY LUMITS? THE YES 2 NO		
BY FUNERAL	100. STREET AND NUMBER 2023 E. 31ST STREET			107. ZIP CODE 212				-	S.A.	
	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2. IF YES, GIVE WAR OR DATES	<b>₹</b> NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (S If yes, specify Cuban, Mexican, Puarto Rica  1 YES 2 XNO Specify:						
LETED	(Specify only highest grade completed)  (Give kin  Elementary/Secondary (0-12)  College (1-4 or 5 +)			NT'S USUAL OCCUPATION d of work done during most of working DT use retired.)  MSTRESS			16b. KIND OF BUSINESS/INDUSTRY PEACO INDUSTRIES			
COMPLET	17. FATHER'S NAME (First, Middle, Lest)  CLARENCE VINEY			LESS	18. MOTHER'S NAME (First, Middle, Malden BESSIE					
TO BE	19a, INFORMANT'S NAME (Type/Print) 19b, MA			ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zig. E. 31ST st. BALTIMORE, M.						
	20s. METHOD OF DISPOSITION  1 N Sourisi 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. PLACEAND DATE OF DISPOSITION (Name of company, crematory or other place)  MT CEMETERY  DATE  20c. LOCATION — City or Town, State  20c. LOCATION — City or Town, State  Company, crematory or other placed  MT CEMETERY  DATE  1 DATE  1 DATE  20c. LOCATION — City or Town, State							THE PROPERTY OF THE PARTY OF TH		
	21. SIGNATURE DE FUNERAL SERVICE DICENSEE  22. NAME AND ADDRESS OF FACHLITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD21213									
NO	23. PART F. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  CARDIOPULMONARY ARREST  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL CI	PART ii. Other algnificant conditions contributing to death but not resu			sulting in the underlying cause given in			ert i. 24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
AN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1  YES 2 NO									
	27. MANNER OF DEATH  1 M Netural 5 Pending  28s. DATE OF INJUR (Month, Day, Yes		Y 28b. TIME OF 1NJURY AT WORK?  1 YES 2 NO  RY — At home, farm, street, factory, office		IK?	28d. DESCRIBE HOW INJURY OCCURED				
red BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLET	29a. CERTIFIER (Check only one)  29a CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  2 MEDICAL EXAMINER: On the beala of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
BE	296. SIGNATURE AND TITLE OF CERTIFIER DR. MAUREEN AHN			29c. LICENSE NU					EDJUNE 23 1995	
70	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  OR. MAUREIN AHM  301 C1 D 709 AL LOMBARD, STREET									
	31. DATE FILED (North 2 Day 1995) 32. REGISTAAR'S SIGNATURE									



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 5 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSHIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNETIAL DIFFICION After this certificate has been signed by the attending physician and completely filled in by the fune within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE	OF OEATH			3. TIME OF DEATH
	Doro		Huta	chins						Jun	e 22	199	YEAR	8:40 AM
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.		IF UNDER		IF UNDER			OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	024-22-6		1 🗆 M 2 💢 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.		13-19	26		sachussett
œ	90. FACILITY NAME (If not in								ON OF DE	ATH		9c. COU	INTY OF D	
DIRECTOR	Johns Ho	pkins	Bayvie	ew M.C	•	Ba	<u>lti</u>	more	e			Ba	ltin	ore City
E I	10e, STATE	10b. COUNTY	1		10c, CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY
	Maryland	Bal	timore		Dı	ında	1k							LIMITS?
M	10e. STREET AND NUMBER						10	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	8435 Kav	anagh						212	222			1	USA	
5	1 Never Married 2	Merried		YES 2	ARMED XNO	1 1	t yes, sp	ecity Cubi	in, Mexicar	n, Puerto 1	7 (Specify Yes Rican, atc.)	or No-	14. RACI Black	E — Americen Indien, k, White, atc.
B	3 Widowed 4 Dive		IF YES, GIVE Y	MAR OR DATES		1	_ YES	2 X NO	Specify	<i>r</i> :			Spec	"White
	15. DEC	EDENT'S EDU	CATION COMPRISED	16e.	DECEDENT'S	USUAL OC	CUPATIO	ON		16b.	KIND OF BUS	INESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (t		College (1-4 or 5	+)	(Give kind of life. Do NOT us	se retired.)	_	al of works	ng					1
MP			2		House	wife	e				Own H			
	17. FATHER'S NAME (First, M Clifford										fiddle, Meiden	Surname)		
BE	19a. INFORMANT'S NAME (				404 444 1144	4000000					erson			
2	Steve Hu		S		8435						er, City or Town			21222
	20a. METHOD OF DISPOSIT	ION	wel from State	20b. PLAC	E AND DATE	OF DISPOSI	TION (N	me of		DATE			City or To	
	4 Donation 5 Other	(Specify)		Oa 1	crematory or o					6-3	24 Ba	ltin	nore	, Md.
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE						SS OF FAC		ral H	OME	of	Dunda1k
	Unitho	ney (	It G	mul	ly.	′	711	0 Sc	olle	rs 1	Point	Rd	2.1	222
	23. PART t. Enter the di ahock, or h	lseases, or c	omplications the	t caused the	death. Do r	not enter	the mo	de of dy	ing, such	aa card	lac or reapli	ratory an	reat,	Approximata Interval Between
	IMMEDIATE CAUSE (Fir disease or condition				0									Onset and Death
ı	resulting In death)	<b>→</b>	n. S	(OR AS A CONS	DECLIENCE A									3 DAYS-
_				cute A			1100	)						NOT KNOW
2	Sequentially list conditi if any, leading to imme-			(OR AS A CONS			010							
ই	cause. Enter UNDERLYI CAUSE (Disease or Inju			IcohoL			sis							NOPKHOWN
	that initieted events resulting in death) LAS	т Т	DUE TO	(OR AS A CONS	SEOUENCE O	F):								
CERTIFICATION			ı											-
	PART II. Other significa	nt condition	contributing to	death but no	t resulting	in the un	derlyin	ceuse (	given in I	Part I.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS
MEDICAL										_ 1	1 TYES 2			COMPLETION OF CAUSE OF DEATH?
- 13										_				1 - YES 2 (NO
Ä	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆				
Š	EXAMINER?	O MEDICAL	HOSPITAL:		ACE OF DEAT	OTHER	:							
Ě	27. MANNER OF DEATN		1 Sinpatient 2 D	INJURY	3 LI DOA		ing Nom 28c. INJ		esidence (	_	(Specify)	LJURY OC	CHBED	
BY PHYSICIAN:		Pending Investigation	(Month, D	lay, Year)		URY M	WO	RK? /ES 2 [	NO				001125	
	3 Suicide 6	Could not be	26e. PLACE O	F INJURY — At atc. (Specify)	home, ferm, e	treet, facto	ery, offic	•		281. LOCA	TION (Street e	nd Number	or Rural F	loute Number,
5	4 Homicide	determined								J., .	. 10111, 01010)			
릴			CIAN: To the best of											
COMPLETED	2 MEDI			xamination end/o	or Investigatio	n, in my op	olnion, d	eath occur	ed at the t	time, date	and place, end	due to th	ne ceuse(e	) end manner ee stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	MD					-	NSE NUM					(Month, Day, Year)
2	30. NAME AND ADMITTESS OF	peneral war	COMBLETES	NE OF DECEME	PEAR CT -				1016				- 22-	
	Tio M. Ha		COMPLETED CAUS				Joh	ns H	OPKI	ns B	21224	· Me	dica	L Center
ŀ	31. DATE FILED (Month. Day)	ybar)		TT 4	U Eas	7 5077	71.0		Jait,	чО	21224			
	JUN 2 3 19	95	IN OTHER	C-BANGATA										



		sit permit. Pages 1, 2, 3 should
020	physician.	burial-trans
BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physician	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE,	er death. Page 6 may be	he funeral director, page
	at a	6

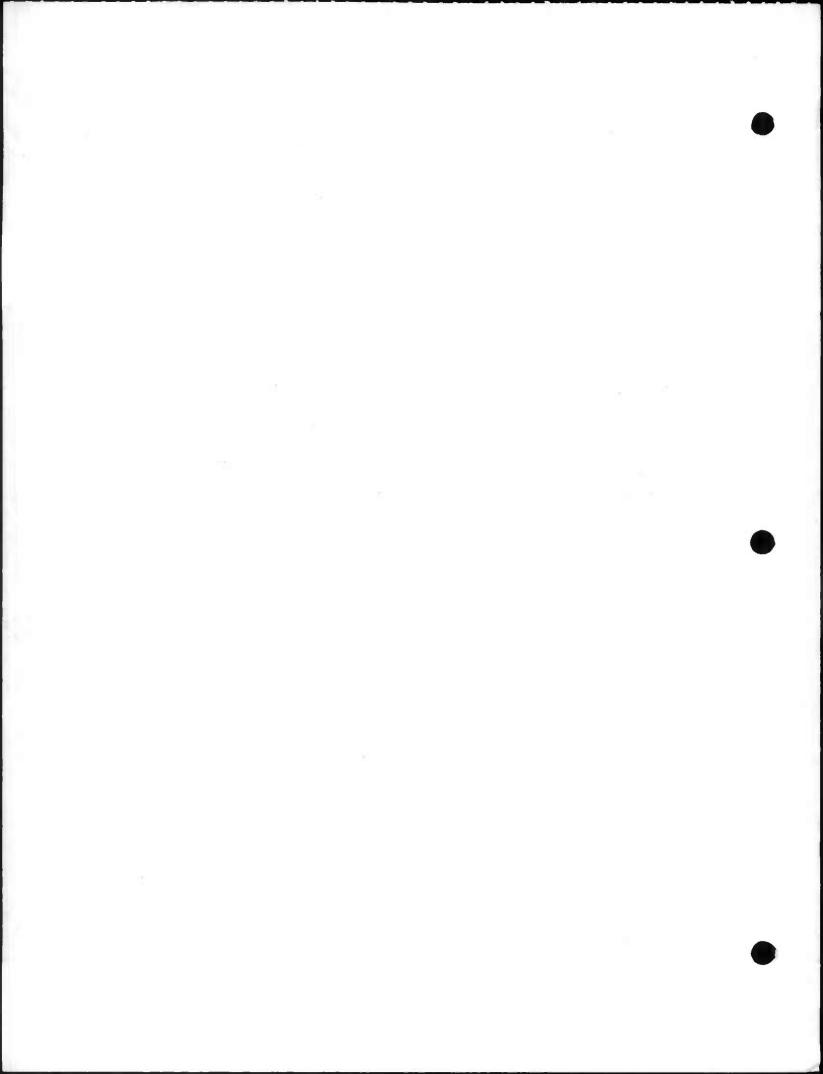
TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

DIVISION OF VITAL RECORDS DO BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		OTALE OF MARK	CI			OF DEAT		LHIAL	REG. NO.	E		
1. DECEDENT'S NAME (First,	, Middle, Last)	-		,		JI DEAI		2. DATE C	OF DEATH			3. TIME OF DEATH
1	auise	THERES	A 1.	ellu	an			TUN	0 2	0	1995	5:430 m
4. SOCIAL SECURITY NUME			E (In yrs. las		F UNDER 1 YE	EAR IF UNDER 2	4 HRS.	7. DATE O	E BIRTN			IPLACE (State or Foreign
215-40-4976	1	☐ M 2½☐ F	92	YRS.	ONTHS DA	HOURS	MIN.	FEB.	21,19	03	Countr MA	RYLAND
9a. FACILITY NAME (If not in	natitution, give street	and number)		9	b. CITY, TO	WN OR LOCATIO	N OF DEA				JNTY OF D	
CHARLESTOWN		NTER			C.	ATONSVI	LLE				BALT	IMORE
10e. STATE	10b. COUNTY			10c. CITY,	TOWN OR L	OCATION						10d. INSIDE CITY
MARYLAND	BALT	'IMORE		C.A	ATONS	VILLE						LIMITS?
10e. STREET AND NUMBER						101. ZIP CODE				10g. CI	TIZEN OF V	VHAT COUNTRY?
715 MAIDEN		LANE -APT					228	1000			U.S.	
1 Never Merried 2 3 Widowed 4 Divo	Married	FORCES? 1 YE	S 2X 1	NO .	If ye	DECENDENT OF a, specify Cuban, YES 2 1 NO				or No-	14. RACE Black Speci	- American Indian, t, White, atc.
15. DEC (Specify only	EDENT'S EDUCATI y highest grade con	ON noieted)	18a. DE	CEDENT'S US	UAL OCCUI	PATION or most of working		16b. 1	KIND OF BUS	INESS/IN	OUSTRY	
Elementery/Secondary (0		college (1-4 or 5+)	lite.	Do NOT use r	etired.)	y most or working						
4TH GRADE			S	ALESCI	LERK				HU	TZLE	R'S I	DEPT. STORE
17. FATNER'S NAME (First, M. PETER STARK	1.1						ER'S NAMI	E (First, Mi	ddle, Maiden (UNKN			
19a. INFORMANT'S NAME (7)			19	b. MAILING AD	DRESS (Str	reet and Number o	or Rural Ro	ute Numbe	r, City or Town	n, State, Zi	(p Code)	
WALTER H. F	HELLMAN					A MILL						131
20a, METNOD OF DISPOSITI		from State		AND DATE OF I		N (Name of		DATE		CATION -	City or To	wn, State
4 Donation 5 Other	* * * * * * * * * * * * * * * * * * * *		NEW C	ATHEDI	ERAL	CEMETER		6/23	BA	LTIM	ORE	
21. SIGNATURE OF FUNERAL	L SERVICE LICENS	V //	~~	m~	HUB	BARD FU	NERA	L HO				
23. PART /Enter the di		/		J V -	410	7 WILKE	NS A	VENU	E - B	ALTI	MORE	MD 21229
iMMEDIATE CAUSE (Fin disease or condition reaulting in death)  Sequentially list conditi if any, leading to immac cause. Enter UNDERLY! CAUSE (Disease or Inju that initiated aventa	a  iona, diata NG ry  c	DUE TO (OR AS	O V Q	OUENCE OF):		Acci	den	+				Interval Between Onset and Death
resulting in death) LAS	T d											
PART II. Other algnifica	nt conditiona c	ontributing to death	but not r	reaulting in	tha under	lying cause gi	van in Pr		24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
						V		_	(			1 _ YES 2 _ NO
DID TOBACCO U		UTE TO CAUSE					RTAIN					
25. WAS CASE REFERRED TO EXAMINER?		OSPITAL:	26. PLAC	E OF DEATH	Check only	one)						
1 TYES 2 NO		inpetient 2 ER/O		DOA 4	Ulursing	Home 5 - Resi						
	Pending Investigation	28a. DATE OF INJUR (Month, Day, Year		26b. TIME C	Υ	WORK?	10	26d. DESC	RIBE HOW IN	JURY OC	CURED	
3 Suicide 6	Could not be determined	28s. PLACE OF INJU- building, atc. (S)	RY — At ho	me, ferm, stre	et, factory,	office	2	City or	TION (Street a Town, State)	nd Numbe	r or Rural R	oute Number,
		d: To the best of my known the bests of exeminate										and manner as stated.
296. SIGNATURE AND TITLE	n /	· Le Co	~~~	11	40	29c. LICEN	3 8	76 a	2	29d. DAT	Jue	(Month, Day, Year) 2/1/1995
30. NAME AND ADDRESS OF	PERSON WHO CO	1	hoi	<b>м 27)</b> (Турв, Рп		ne.	6	Bal	+, /	Yd.	2	1228
JUN2 3	1995 8	LA CURLINATE SIC	Tara.	岐								



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

or death. Page 6 may be retained by the hospital or attending physician.	he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		examiner must be notified at once.	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Last)					2. OATE OF DEATH		3. TIME OF DE	ATH
	GERALD HAYES					June 1	7 199	6:20	D. M
		Grand .	yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Country)	Foreign
	215-28-5189 1 9e. FACILITY NAME (If not inetitution, give stree		5 YRS.	OF CITY TOWN	OR LOCATION OF DI	03/31/30	Ba COUNTY	ltimore,	MD.
R	DVA MEDICAL CENTE				HOWARD,		CITY	OF DEATH	
5	RESIDENCE OF DECEDENT  10e, STATE 10h, COUNTY			Y. TOWN OR LOCAL					
DIRECTOR	MARYLAND CITY		241	,	RD, (BAL	TIMODE \		10d, INSIDE CI LIMITS? 1 (X) YES 2 [	
	10e. STREET AND NUMBER				ZIP CODE	TIMORE)	10g. CITIZEN	OF WHAT COUNTRY	
FUNERAL	2710 GATEHOUSE DR.				21217		USA		
J.	11. MARITAL STATUS  1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U FORCES? 1 X YES	2 NO			NIC ORIGIN? (Specify Year, Puerto Ricen, etc.)	s or No- 14.	RACE — American In Black, White, atc.	dlen,
BY	3 Widowed 4 Divorced	1951 - 1954	ES	1 TYES	2 NO Specif	у:	B	LÁCK	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION 1		USUAL OCCUPATION		16b. KIND OF BU			
Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	•	1/0.15			
OM	17. FATHER'S NAME (First, Middle, Lest)	0	TRUCK	DRIVER	18 MOTHER'S NA	ME (First, Middle, Melder	OMPANY		
ш	ISIAH HAYES				RUTH		COOPER		
TO B	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Route Number, City or Tox	vn, State, Zip Cod	,	
-	BARBARA R. HAYES					, BALTIMOR			17
	20e. METHOD OF DISPOSITION  1 XI Burlet 2 Cremetton 3 Remova 4 Donation 5 Other (Specify)	of from State 20b. P	LACEAND DATE	DE DISPOSITION (No	me of	6/22/95 OW	CATION — City	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	AINT JUN	22. NAME AP	ID ADDRESS OF FA	CILITY	TNG MIL	L, MD.	
	Dough M	() to	1	ESTEP	BROTHER	S FUNERA1 ACE, BALTI	SERVICE	E,P.A.	
	23. PART I. Enter the diseases, or con	nplications that caused t	the deeth. Do r	not enter the mo	de of dying, auc	has cerdied or reep	MUKE, I	10. <u>2121/</u> ,   Approxi	mate
	anock, or heart failure. Lis	t only one cause on eec	h Ilna.					Interval	Batween nd Death
	disease or condition reaulting in death)	ALCOHOLIC LI						Sing	8
		DUE TO (OR AS A C							
S S	Sequentially list conditions, if any, leading to immediate	INSULIN DEP						197	0
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	PNEUMONIA						6/10	6/95
CERTIFICATION	thet initieted eventa resulting in death) LAST	DUE TO (OR AS A C		•					
		IV HEROIN DE						195	
Z	PART II. Other algorificant conditions of PEPTIC ULCER DISEA					PERFO	RMED?	24b. WERE AUTOPSY AVAILABLE PRIO	OR TO
PHYSICIAN: MEDIC	G.I. BLEEDS, HYPER		JIMAN SUL	GERI (BI	ED. 95)	1 YES :	ĭ (¥NO	OF DEATH?	
Σ ;	DID TOBACCO USE CONTRIB		DEATH YE	S I NO X	UNCERTAI			1 TYES 2	NO
SIA	25. WAS CASE REFERRED TO MEDICAL	26		TH (Check only one)	OTTOLKI7411				
YSI	1 _ YES 2 \ NO 1	OSPITAL:	lent 3 🗆 DOA	OTHER: 4 - Nursing Hom	e 5 🗆 Residence	8 Other (Specify)			
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	RK?	28d. DESCRIBE HOW	INJURY OCCURE	EO	
BY	2 Accident Investigation	28e. PLACE OF INJURY -	- At home, farm, s		ES 2 NO	28f, LOCATION (Street	and Number or F	Jural Bouta Number	
COMPLETED	4 Homicide 8 Could not be determined	building, etc. (Specify,	)	, , , ,		City or Town, Stete	)	ioral Proble Profitori,	
PLE	29s. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowled	ige, death occurre	ed at the time, data	end place, end dua	to the cause(s) end ma	nner as steted.		
MO		On the basis of examination s						iuse(e) end menner ed	stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Magain			29c. LICENSE NUM		29d. DATE SK	GNED (Month, Day, Yea	(r)
0	30. NAME AND ADDRESS OF PERSON WHO C	Z	U // PP/	0.00	D3052	-8	6	17 95.	
	DR. DUGGIRALA, BAL					RT HOWARD,	MD	21.052	
	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGNAT	URE	T OTIVE I	CAD, FUI	LI HOWAKD,	MD.	21052	
	JUN 2 3 1995 Julia	Studen Randal	LL.						

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	68.	
	be notified at or	
- AGI.	i examiner must	
remaindle, or ferring	ent, the medica	
o prior to come,	er traumatic ev	
and morning of groun	y injury, or othe	
	-	1

ITEMS: 20a,b,c per MD 6/23/95 G-724 reb
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAI	RTMENT O	F HEALTH AND	D MENTA					
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH	DAY	YEAR	3. TIME OF DEA	ХТН
	Marie 4. SOCIAL SECURITY NUMBER	E GEV & ACE				6-	2	22 95		12:10	Ам
		1 M 2 F	VDC			(Mon	th, Day, Year)		Country	)	Foreign
	218-26-1944  9e. FACILITY NAME (If not institution, give st	HUPPMAN    1									
DIRECTOR	Franklin Square H	ospital									-
H.	10a. STATE 10b. COUNTY								$\neg$	10d. INSIDE CIT	Υ
		imore	Fu	lllerto	n					1 TES 2	NO
FUNERAL	10e. STREET AND NUMBER				- 1					AT COUNTRY?	
뷥	3 Fullerton Hei		IN U.STARMED	12 WM S		BANIC ODICE	Marak. W			400 400 4	
	1 Never Married 2 X Married	FORCES? 1 TYES	2 1 NO	If ye	s, specify Cuben, Mer	rican, Puerto	Rican, etc.)	s or No-	Black,	White, etc.	llan,
5	3 Widowed 4 Divorced				TES 2 M NO Spi	вспу.			Speciny		
₫	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kind of	work done durin		16	. KIND OF BL	JSINESS/INDUS	TRY	WILLE	
ן ב	Elementary/Secondary (0-12)	College (1-4 or 5+)					-			1.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		I Clerica	11	46 1407115010				Suil	ding	
_					12507			n Sumame)			
B	19a. INFORMANT'S NAME (Type/Print)	0	19b. MAILING	G ADDRESS (St				wn Stete Zin C	orie)	<del></del>	
2	Edmund W. Huppman									21236	
	20s. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITIO							
	4 Donation 6 Other (Specify)		Holv Rede	eemer (	Cem. (	5/26/9	5 Bai	ltimor	e. M	ID.	
1	21. SIGNATURE OF FUNERAL SERVICE LIQ	estree ///	· ·								TNO
	Justin IL	Sikkel 4		711	O Rolair	Pond					INC.
٦	23. PART . Enter the diseases, or o	omptications that cause	ed the death. Do	not enter the	mode of dying, s	uch as car	diac or resp	piratory arrea	t,	Approxim	ate
- 1										Onset an	
	disease or condition resulting in death)	Coron	ions f	tote	a in	120	ase	Anes	4	150	m
		DUE TO (OR AS	A CONSEQUENCE C	F):			7			10	12
5	Sequentially list conditions,	Hypert	entron							17	
	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	F):				•		1	
	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	E COULA						3.	745
	resulting in death) LAST			,							
CERTIFICATION	PART II Other significant conduction	a contribution to the state	had not not not	I- Ab					_	1	
\$	rant ii. Other alignificant conditions	contributing to deeth i	out not resulting	in the under	lying cause given	in Part I.			1	WAILABLE PRIOR	TO
MEDIC							1 TYES	NO NO		COMPLETION OF	
	DID TORACCO LISE CONTR	IDLITE TO CALLER O	DE DEATH W	rc 🗖 210	T III.arr				1	YES 2	NO
AN	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE (				AIN L	-		-		
PHYSICIAN:	EXAMINER?		_	OTHER:			- 10 11 :				
	27. MANNER OF DEATH	28s. OATE OF INJURY	28b. TIR	E OF 28c	. INJURY AT	1	. ()	INJURY OCCUR	RED		
2											
	3 Suicide 8 Could not be	28e. PLACE OF INJUR	Y — At home, ferm,	street, factory,	office				Rurel Ro	ute Number,	
	4 Homicide determined					City	or lown, state	,			
COMPLE	29e. CERTIFIER (Check only	CIAN: To the beat of my know	wledge, death occum	ed at the time,	date end place, end d	fue fo the ca	use(s) end me	nner as stated.			
									ause(e)	end manner ea a	risted.
	296. SIGNATURE AND TITLE OF CERTIFIER										
- 611	D Cellerten	- vmo			D44.	271		> G1	22	185	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	F321 BE	Print)	DY4	scits	40 8	1236	,		
	31. DATE FILED (Month), Day 3500 JUN 2 3 1995	Hasekine for	halle					_			
- 18	HILLY ATOUR MA	AND IN THE OWNER OF THE									

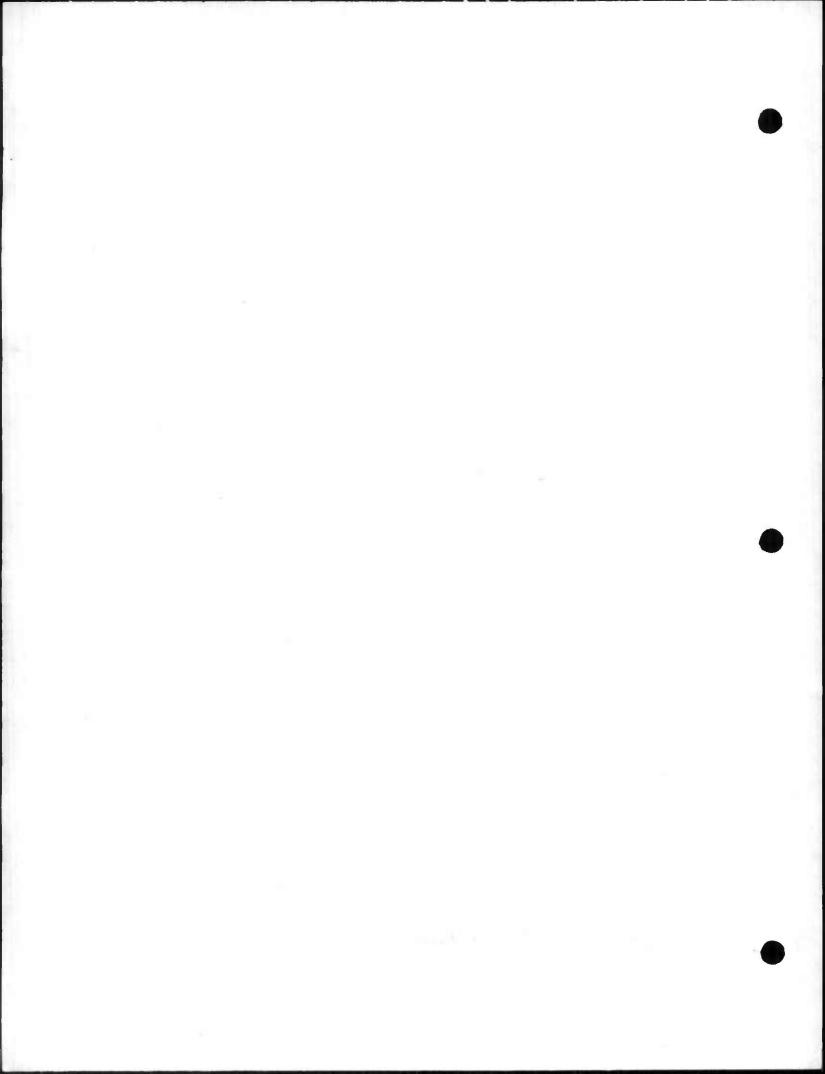
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funisharmoris power 1.2.3 chould	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ath. Page 6 may be retained by the hospital or attending physician.	uneral director, page 5 should be detached for use as the burial-transit parmit Pages 1.2.3 should	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPER	aminer must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE OF MA STATE REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	RYLAND / DEPART	MENT OF HEALTH AND			
		CATE OF DEATH			
- The state of the	OLIVITIC	DATE OF DEATH	REG. NO.		3. TIME OF DEATN
John Paul Holmon			MONTH 6 DAY	20 GEAR	930 am
4. SOCIAL SECURITY NUMBER 5. SEX 6.		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTN	PLACE (State or Foreign
9e. FACILITY NAME (If not institution, give street and number)		Pb. CITY, TOWN OR LOCATION OF D	EATN 9	c. COUNTY OF D	
Baltimore V.A. Hospital		Baltimore		N/A	
RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY					
Maryland Baltimore		town on Location unda1k			10d. INSIDE CITY LIMITS? 1 YES 2XXNO
10e. STREET AND NUMBER		10t, ZIP CODE		g. CITIZEN OF W	HAT COUNTRY?
2903 Dunmurry Rd.		21222		U.S.A.	
11. MARITAL STATUS 1 Never Married 2 Married FORCES?	VER IN U.S. ARMED YES 2 NO	13. WAS DECENDENT OF NISPAI If yes, specify Cuben, Maxica	IIC ORIGIN? (Specify Yea or	No — 14. RACE	- American Indian, White, etc.
3 Wildowed 4 Divorced IF YES, GIVE WAR	OR DATES WW 11	1 TES XX NO Specif		Specif	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US (Give kind of wor	k done during most of working	16b. KIND OF BUSINE	SS/INDUSTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)	Sales	retired.)	Paint		
17. FATNER'S NAME (First, Middle, Last)			ME (First, Middle, Melden Surr		
Howard Willard Holman		Genev			Smith
190. INFORMANT'S NAME (Type/Print) Michael J. Holman		olling View Ave			nd 21236
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☆ Cremetion 3 ☐ Removal from State 4 ☐ Donalion 5 ☐ Other (Specify)	20b. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LOCATI	ION — City or Ton	wn, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Green Hour			nore, Man	yland
· Steve 1. out		22. NAME AND ADDRESS OF FA Mitchell-Wie 6500 York			
23. PART I. Enter the diseases, or complicatione that conshock, or heart failure. List only one cause	aused the death. Do not	enter the mode of dying, suc	h aa cerdiac or reapireto	ory arrest,	Approximete
IMMEDIATE CAUSE (Final		4			Onset and Death
disease or condition	AS A CONSEQUENCE OF):	Rak			
Sequentially list conditions, b. Derip	MICC INCIDENCE				
	evel actor to	rdinan			
ii any, leading to immediate	AS A CONSEQUENCE OF):	rdinan			
CAUSE (Disease Dr Injury	AS A CONSEQUENCE OF):	rdinan			
cause. Enter UNDERLYING CAUSE (Disease or Injury	AS A CONSEQUENCE OF):	rdinan			
cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	AS A CONSEQUENCE OF):				
cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  DUE TO (OR	AS A CONSEQUENCE OF):		Part I. 24s. WAS AN AUT		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	AS A CONSEQUENCE OF):			07	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent conditions contributing to dea	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not resulting in	the underlying cause given in	PERFORMED	07 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significent conditions contributing to death the conditions contributing the conditions contributing the conditions contributing the conditions contributing the conditions contributing the conditions conditions contributing the conditions conditio	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not resulting in  SE OF DEATH YES	the underlying cause given in	PERFORMED  1 TYES 21	07 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  Ath but not resulting in  SE OF DEATH YES  28. PLACE OF DEATN	the underlying cause given in	PERFORMED  1 TYES 21	07 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO   NO   YES 2   EN    TO SERVICE OF TO SERVICE OF TO SERVICE OF THE SERVICE OF	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  BE OF DEATH YES  26. PLACE OF DEATN  COMPARIENT 3 DOA  4	the underlying cause given in  NO UNCERTAIN (Check only one)  THER: Nursing Home 5   Residence	PERFORMED  1 YES 216  8 Other (Specify)	07 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE OF TOWN AND CAUSE TO	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not resulting in  SE OF DEATH YES  26. PLACE OF DEATN  COUNTERING 3 DOA 4  URY 28b. TIME C	the underlying cause given in  NO UNCERTAIN (Check only one)  THER: Nursing Home 5   Rasidence OF 28c. INJURY AT WORK?	PERFORMED  1 YES 24	07 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DISEASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  TO MANNER OF DEATN  1 Natural 5 Pending (Month, Day) (Month, Day) (Month, Day) (Month, Day) (28 PLACE OF IN)	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not resulting in  SE OF DEATH YES  26. PLACE OF DEATN  VOutpetlent 3 DOA 4  URY  28b. TIME C  INJUR	the underlying cause given in  NO UNCERTAIN (Check only one)  ITHER: Nursing Home 5   Residence  OF 26c. INJURY AT WORK? M 1 YES 2 NO	PERFORMED  1 YES 21  8 Other (Specify)  28d. DESCRIBE NOW INJUI	NO RY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR d. DID TOBACCO USE CONTRIBUTE TO CAUSE DID TOBACCO USE CONTRIBUTE TO CAUSE EXAMINER?  DID TOBACCO USE CONTRIBUTE TO CAUSE DID TOBACCO USE CONTRIBUTE DID TOBACCO U	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  BE OF DEATH YES  26. PLACE OF DEATN  CONSEQUENCE OF):  26. PLACE OF DEATN  CONSEQUENCE OF):  27. PLACE OF DEATN  CONSEQUENCE OF):  A CONSEQUENCE OF):  BURY 28b. TIME CONSEQUENCE OF):  BURY 28b. TIME CONSEQUENCE OF):  BURY 28b. TIME CONSEQUENCE OF):	the underlying cause given in  NO UNCERTAIN (Check only one)  ITHER: Nursing Home 5   Residence  OF 26c. INJURY AT WORK? M 1 YES 2 NO	PERFORMED  1 YES 216  8 Other (Specify)	NO RY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DISEASE) TO MEDICAL EXAMINER?  1 YES 2 NO  1 Manner of Death  1 Natural 5 Pending Investigation  2 Accident Investigation  3 Suicide 6 Could not ba determined  20 CONTRIBUTE TO CAUSE CONTRIBUTE CO	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):	the underlying cause given in  NO UNCERTAIN (Check only one)  ITHER: Nursing Home 5   Residence  Province   Nursing Home 5   Residence  Residence   Nursing Home 5   Nursing Home 5   Residence  Province   Nursing Home 5   Nursing Home 5   Residence	PERFORMED  1 YES 210  8 Other (Specify)  28d. DESCRIBE NOW INJUI  281. LOCATION (Street and In City or Town, State)	NO RY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DISEASE) TO MEDICAL EXAMINER?  1 YES 2 NO  1 Natural 5 Pending Investigation (Month, Day, Yang and Homicide)  1 Natural 5 Could not ba determined	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not reaulting in  SE OF DEATH YES  26. PLACE OF DEATN  VOutpatient 3 □ DOA 4  URY 28b. TIME C (Specify)  knowledge, death occurred a	the underlying cause given in  NO UNCERTAIN (Check only one)  ITHER: Nursing Home 5 Residence  FY 28c. INJURY AT WORK? 1 YES 2 NO  set, fectory, office	PERFORMED  1 YES 21  8 Other (Specify)  28d. DE\$CRIBE NOW INJUI  28f. LOCATION (Street and Northly or Town, State)	NO OCCURED  Number or Rural Rules as stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DISEASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  1 Matural 5 Pending Investigation 28a. DATE OF INN (Month, Day, 1) (Month, Day, 1) (Month, Day, 1) (Month, Day, 2) (Month, Day, 3) Suicide 6 Could not ba determined 29a. CERTIFIER (Check only 1) CERTIFIYING PHYSICIAN: To the best of my	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):  ath but not reaulting in  SE OF DEATH YES  26. PLACE OF DEATN  VOutpatient 3 □ DOA 4  URY 28b. TIME C (Specify)  knowledge, death occurred a	the underlying cause given in  NO UNCERTAIN (Check only one)  ITHER: Nursing Home 5 Residence  FY 28c. INJURY AT WORK? 1 YES 2 NO  set, fectory, office	8 Other (Specify) 28d. DESCRIBE NOW INJUI 28f. LOCATION (Street and It City or Town, State)  10 the cause(a) and manner time, data and place, and du	NO OCCURED  Number or Rural Rules as stated.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DISEASE) TO MEDICAL EXAMINER?  1   YES 2   NO	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):	the underlying cause given in    NO	8 Other (Specify) 28d. DESCRIBE NOW INJUI 28f. LOCATION (Street and It City or Town, State)  10 the cause(a) and manner time, data and place, and du	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.
CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DID TOBACCO USE CONTRIBUTE TO CAUSE (DID TOBACCO USE CONTRIBUTE TO CAUSE EXAMINER?  DID TOBACCO USE CONTRIBUTE TO CAUSE (DID TOBACCO USE CONTRIBUTE TO CAUSE (Morth, Dev.) (Morth, De	AS A CONSEQUENCE OF):  AS A CONSEQUENCE OF):	the underlying cause given in    NO	8 Other (Specify) 28d. DESCRIBE NOW INJUI 28f. LOCATION (Street and It City or Town, State)  10 the cause(a) and manner time, data and place, and du	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Dute Number,  and manner as stated.



PM

White

1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 JUNE 18 1:30 HIHN Edmund CRAIG Steuart 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign October 18 HOURS 212-50-4626 47 DAYS 1 X M 2 | F Maryland 1947 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A RESIDENCE OF DECEMENT BALTIMORE 10h COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Maryland Baltimore 1 X YES 2 NO permit 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 815 South Bond Street 21231 funeral director, page 5 should be detached for use as the burial-transit United States retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2/2NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Ric 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Louis Ellsworth Hihn Rosalina Edmonds BE Rosalind notified 190.Rosalind - Type/Print)
Rosalina E. Hihn 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 417 Woodbine Avenue Towson, Maryland 21204 Page 6 may be pe 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 1 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Greenmount Crematory 6/20 ■ □ Dignation 5 □ Other (Specify) \_ Baltimore, Maryland examiner MATURE OF FUNERAL SERVICE MICENSE 22. NAME AND ADDRESS OF FACILITY
Mitchell-Wiedefeld Home, Inc. hours after death. 6500 York Road Baltimore, Maryland 21212 completely filled in by the I medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, Approximata shock, or heart fallure. List only one cause on each line. Interval Between ŏ IMMEDIATE CAUSE (Final **Onset and Death** #e disease or condition DUE TO (OR AS A CONSEQUENCE OF) sur resulting in death) mal traumatic event, Crem the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68769 the attending physician and con Mental Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the that any YES 2 NO OF DEATH? shows YES 2 NO of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL DR ATTENDING PHYSICIAN: The certificate h HOSPITAL OTHER: 1 XYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Kasidenca 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, this with Natural 1 YES 2 NO After the BY 2 Accident 28a. PLACE OF INJURY — At home, larm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 DIRECTOR: / COMPLETED 6 Could not be 4 Homicide 28 determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL ITO THE FUNERAL DIDE filed within 72 hr (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. an JUNE 19,1995 2 30. NAME AND ACORESS OF PERSON WHO COMPLETED JUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

111 Penn Street, Baltimore, Maryland 21201

, \*  ITEMS: 28a-f, PER MEO FILM G-729 11/8/95 t.t

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME Jeffery	L. KAN	r.			JUNE		, 19Š		TIME OF DEAT
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	# I I I I I I I I I I I I I I I I I I I	T					0826
	218-92-7794 9a. FACILITY NAME (If not institution, give st	1 📈 M 2 🗆 F	23 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURE MIN.		Day Year)	971	Country)	Md Md
TOR	NORTH ARUNDEL		E.R.	ANNAP	OLIS	EATH		ANNE		H JNDEL
DIRECTOR	10a. STATE 10b. COUNTY	Arundel		y, town on Loca Sadena	TION				100	I. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 4202 Forsythia	Lane			ZIP CODE				OF WHAT	COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	CENDENT OF HISPAI Hecity Cuban, Mexico 5 2 NO Specifi	an, Puerto Ric		or No- 14	RACE — Black, WI Specify:	American India hita, etc.
	15. DECEDENT'S EDUC	ATION	18e. DECEDENT'S	USUAL OCCUPATION	ON	16b. I	UND OF BUS	INESS/INDUS	TRY	Diaci
COMPLETED	(Specify only highest grade   Elementary/Secondary (0-12)   12th grade	College (1-4 or 5 +)	Give kind of v life. Do NOT us Labor	•	ost of working			k Co.		
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA			Sumame)		
BE	Leon Albert Kane				Patrici		eves			
2	Patricia Kane				and Num Road			, State, Zip Co		01100
		l an			Veck -Rao	7	_	adena		
	20s_METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Remo 4 Donation 8 Other (Specify)	val from State	b. PLACE AND DATE OF PLACE OF PLACE AND DATE OF PLACE OF	ther place)	ame of	62/1C		n Buri		
	21. SIGNATURE OF FUNERAL SERVICE LICE		aren nave		ND AODRESS OF FA		7 010	II bui i	ne,	Mu
	1 3/101	2 6.1	_/)	Marc	ch F/H We	est				
	23. PART I. Enter the diseases, or c	omnileations that course	od the death. De c	4300	Wabash					Approxima
	ahock, or heart fellure. I	Narcotic	Intoxica A consequence of							Onset and
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated exerts DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
ERTIF	that initiated events resulting in deeth) LAST		A CONSEQUENCE OF	·):						
MEDICAL (	PART II. Other aignificent conditions	contributing to daeth i	but not resulting i	n the underlyin	g ceuse given in		PERFORI	MED?	AWA	RE AUTOPSY FII ILABLE PRIOR ' MPLETION OF C DEATH?
	DID TOBACCO USE CONTR	IDLITE TO CALLEE C	DE DEATH VE	5 T NO T	1				15	YES 2   N
AN	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE C	26. PLACE OF DEAT		UNCERIAII					
PHYSICIAN:	EXAMINER?  1X X ES 2 NO	HOSPITAL: 1 ☐ Inputlant 2 X ER/Out	T	OTHER:	e 5 🗆 Residence	8 🗆 Other (	Specify)			1
됩	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJ				JURY OCCUR	ED	-
BY	1 Natural 5 Pending 2 Accident Investigation	FOUND: 6-17-	-95 UNKNO	WN <sup>M</sup> 1	YES ZXX NO	UNKNO	WN			
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, s polity) IN CAR	treet, factory, offic		City or	ION (Street ar Town, State)	nd Number or I	Rural Route	Number,
COMPLETE		CIAN: To the best of my know				to the cause	e(e) and mans		suse(s) and	l menner as at
w I	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			29d. DATE SI		
∞	Nignald & IN	right MM			O.C.M	1.E				3,1995
٩	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR	EATH (ITEM 27) (Type, 1111 Pen		et, Bal	Ltimo	re, l	Maryl	and	2120
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	A							
	WWW 0 0 400F	1. 1: Abuntan	Rowlell							

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPIT.  TO THE FUNERA  DE filed within 7  IMPORTANT: I	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filled within 72 hours after death with the State Deor, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	Item17	6-30-95	FilmG724	W.H.Pe	r F/	H		C	15	18904
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND / (	DEPARTMEN RTIFICAT				IYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH		3. TIME OF DEATH
	ELEANO	5 4	ARLO	CK			MONTH	21	95	9,05PH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest t		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I	BIRTH	B. BH	RTHPLACE (State or Foreign
	397-14-7255	1 🗆 M 2 🖔 F	71	YRS. MONTHS	DAYS	HOURS MIN.	March	8, 192		wisconsin
	9a. FACILITY NAME (If not institution, give at	ution, give street and number)  9b. CITY, TOWN DR LOCATION OF DEATH  9c. COUNTY								
8	Howard County G	eneral H	ospital		Col	lumbia			Howa	ard County
<u> </u>	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									
DIRECTOR		roll Cou		sburg				10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER							140-	O.T. Tarris	1  YES 2 X NO
₩.	1151 Small Oak		"	f. ZIP CODE	Q /ı	109		S.A.		
Z MARITAL STATUS										
	1 Never Married 2 Married	FORCES? 1	YES 2 NO		If yes, sp	ecity Cuban, Mexico	an, Puerto Ricar	n, atc.)	Bi	ACE — American Indian, lack, White, etc.
BY	3 Widowed 4 Divorced	# 123, GIVE V	WH OH DATES		1 [] TES	2 X NO Speci	y:		Sp	White
0	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed	16a. DECE	EDENT'S USUAL	OCCUPATION	ON	16b. KIN	D OF BUSINES	S/INDUSTRY	1
9	Elementary/Secondary (0-12)	College (1-4 or 5	lide D	o NOT use retired.	)	ist of working				
COMPLETED	12		Emp	oloyee 1	Relat	tions		C	lerio	cal
00	17. FATHER'S NAME (First, Middle, Last)	Haman	n			18. MOTHER'S NA				
BE	Henry <del>Hayman</del>	,						Schurz		
TO	190. INFORMANT'S NAME (Type/Print)  Mr. John Karlock					and Number or Rural  Ak Court				
	20a. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Ramo	well from State	20b. PLACE AN	D DATE OF DISPO	SITION (Na	ame of	DATE	20c. LOCATIO	N — City or	Town, State
	4 Donation 5 Other (Specify)		Crestl	awn Mer	n. Ga	ardens	6/24/9	Marr	iotts	sville, MD
	21. SIGNATURE DF FUNERAL SERVICE LIC	ENSEE	, ,			ND ADDRESS OF FA		7 (D 0	D	105)
	Volum of	- Huig	ut			HT FUNERA				
	23. PART I. Enter the diseases, or c	omplications tha	t ceused the deat	h. Do not ente	r the mo	de of dying, suc	h as cerdiac	or reapirator	y arrest,	Approximate
	ahock, or heart fellure. I	List only one ceu	iaa on aach lina.							Interval Between Onset and Death
	disease or condition resulting in death)	META	STATIC	LUA	VG	CANC	ER			10 MONTHS
	readiting in death)		(OR AS A CONSEDU							
Z	Convention that are distance of	)								
일	Sequentially list conditiona, if any, leading to immediate	DUE TO	(OR AS A CONSEDU	ENCE OF):						
2	CAUSE (Disease or injury	À								
불	that initiated events resulting in death) LAST	OUE TO	(DR AS A CONSEQU	ENCE DF):						
CERTIFICATION	toothing in boatin, error									
_ 1	PART II. Other algnificant conditions	contributing to	death but not rea	ulting in the u	nderlyln	g cause given in	Part I. 24s	. WAS AN AUTO	PSY 2	4b. WERE AUTOPSY FINDINGS
3	N/A							PERFORMED?	- 1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
밀								1 150 Sec. 10		OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEATH	H YES 🔀	NO [	UNCERTAI	$\Box$			, [ 123 2 [ ND
X	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			DF DEATH (Check						
Sic	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	DOA 4 Nu		e 5 🗆 Realdence	6 Other (Sp	ecify)		
숮	27. MANNER OF DEATH	26a. DATE OF (Month, D		266. TIME OF INJURY	28c. INJ			BE HOW INJURY	OCCURED	
BY I	1 Natural 5 Pending 2 Accident Investigation	NI		NAM	1 🗆		~/	A		
	3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At home atc. (Specify)		ctory, offic	4		N (Street and Nu wn, State)	mber or Run	al Route Number,
COMPLETED	4 Homicide determined		N	A			~/	7		
7	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, death	h occurred at the	time, data	and place, and due	to the cause(a	) and manner as	atated.	
NO.										e(a) and manner as stated.
E C	291 SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI				ED (Month, Day, Year)
00	Bilaigu-	m j				D4113		•	6/21	195
C 3		COMPLETED CAUS	SE DE DEATH (ITEM 1	27) (Type, Print)	0.0		0 1001	CH -	( -	, , ,
2	30. NAME AND ADDRESS OF PERSON WHO	ODMI LETED CHA	DE DE DEATH (ITEM 2	7176-1	CYE	un en .	31 1CV1	7 17 /		
٢	30. NAME AND ADDRESS OF PERSON WHO 11065 LITTLE PA	THYEN?	PARKW	AY, C	of him	BIA	4.D.	2014	+	
T.	31. DATE FILED MYTH 2003 MASS	JUNENT THE	PARK W	AY C	ohun	BIA,	۵,).	2014	+	

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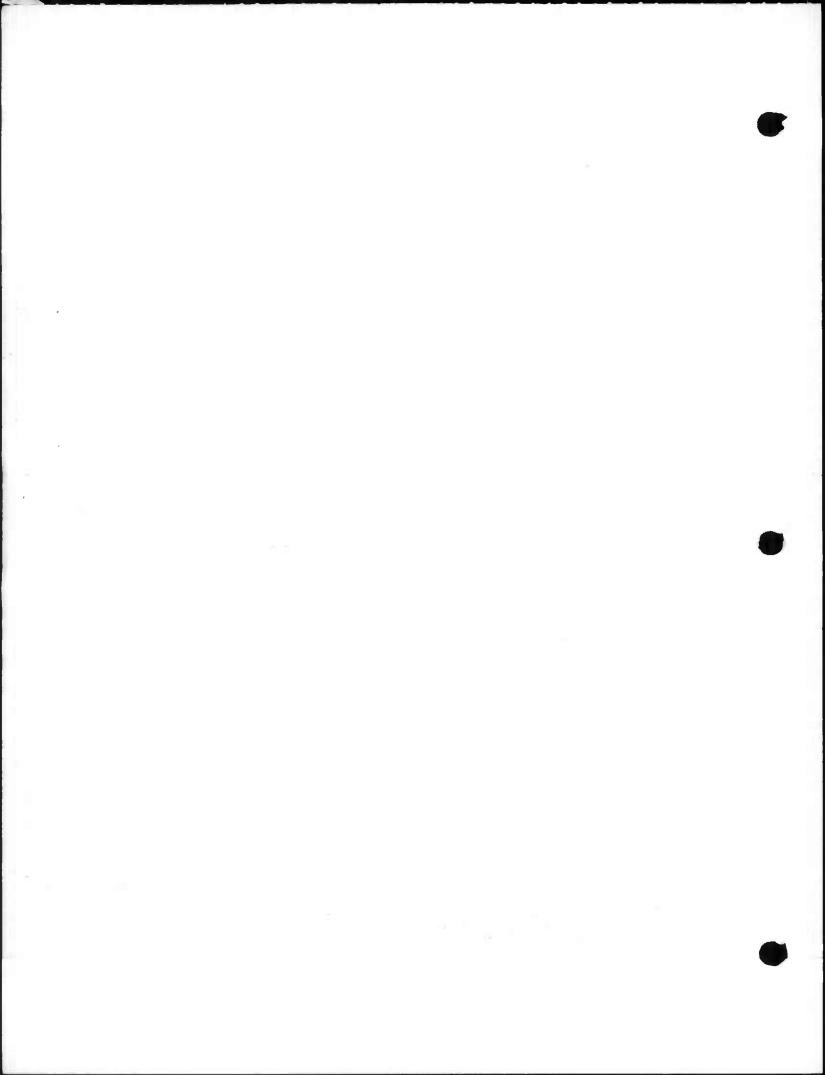
		DECEDENT'S NAME (FIRST, MIGGIR, LBST)      SOCIAL SECURITY NUMBER		ETTMAN  s. last birthday)   IF UNDER t Y	EAR OF UNDER 24 HRS.	2. DATE OF DEATH DO THE TOTAL PARTY OF DEATH	1995	3. TIME OF GEATN 5:40 a M
pinous		000 00 000	□ M 2 X) F 83	YRS. MONTHS D	AY8 HOURS MIN.  WN OR LOCATION OF D		911 NI	EW YORK
1, 2, 3 sho	CTOR	MANOR CARE OF P			POTOMAC	EATH	MONTG	
Pages	DIRE	MARYLAND MONT	GOMERY	10c. CITY, TOWN OR I	OCATION ER SPRINC	3		10d. INSIDE CITY LIMITS? 1  YES 2 NO
in. ansit permit.	FUNERAL	100. STREET AND NUMBER 11500 INTERLACH			101. ZIP CODE 20906			S.A.
5-0020 nding physician. Is the burial-transit	BY FUI	11. MARITAL STATUS  1	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ZNO If ye	DECENDENT OF NISPAI s, specify Cuben, Mexico YES 2 NO Specif		Ble	CE — American Indian, ock, White, etc.
D 2121 opital or atte ed for use	PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.  Elementary/Secondary (0-12)  — 1 2 —	moleted)	DECEDENT'S USUAL OCCU (Give kind of work done durit life. Do NOT use retired.) Iministrat Sistant	a most of wadden	Librar		ongress
M the de de de de de de de de de de de de de	BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Benjamin Franken	stein		Florer	ME (First, Middle, Melden ace Benja	min	
- 2 8	TO BE	Nancy Wanicur  Nancy Wanicur		196. MAILING ADDRESS (S	kman Pl.	Potomac,	Md. 20	
MOR me 6 m		1 M Burlel 2 Cremation 3 Renove 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE ICE	Juc		Gdns.	6/19 Olr	ney, Ma	
SAL r death	- Creating	Chours &	Select	FAL	LS CHURCH	FUNERAL I, VA. 22	046	
y filled in tition, or re-	and the manual state of the sta	73. PART I. Entar the diseases, or conshock, or haert failure. List MMEDIATE CAUSE (Final disease or condition resulting in dasth)	COYONARY OUE TO (OR AS A CON	iina.	mode of dying, suc	h ee cardiac or reapi	ratory arreat,	Approximate interval Between Onset and Death
O. BOX 5870 sertificate be executed ing physician and com- regione prior to burial.	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Diffuse A	theroscle: HEEOUENCE OF): brillation		ebrovascu	ular diseas	20 Year 6 month
OKDS, I that the deat ed by the atte	MEDICAL CE	PART II. Other algnificent conditions of	contributing to death but no	ot resulting in the under	lying ceuse given in	Part I. 24a. WAS AN PERFOR	IMED?	Ib. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
		DID TOBACCO USE CONTRIE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?		LACE OF OEATH (Check only		V 🗆		
PHYSICIAN: The this certificate with the State	5 2		Inpatient 2 ER/Outpatient 28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF 286	Home 5 Residence INJURY AT WORK?	6 Other (Specify) 28d. OESCRIBE HOW IN	NJURY OCCUREO	
1 = 22	ED BY P	Accident Investigation  3 Suicide 8 Could not be detarmined	28s. PLACE OF INJURY — At building, etc. (Specify)		YES 2 NO	28t. LOCATION (Street e City or Town, State)	ind Number or Rural	Route Number,
SIN OUR	MPLET	need .	N: To the best of my knowledge					
TO THE HOSPITAL ( TO THE FUNERAL DE filed within 72 h	BE CO	296. SIGNATURE AND TULE OF CERTIFIER	On the basis of examination and	/or investigation, in my opini	on, death occured at the 29c, LICENSE NUI			(e) and manner ee stated. (D (Month, Day, Year)
668	TO	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH (	ITEM 27) (Type, Print)	D3601:	2	6/1	7/95
40		Thomas J. McNam A1. DATE FILEO (Month, Day, Year) FIN 2 3 1995	ara, MD 50	502 Shield	s Dr. Be	thesda, M	id. 208	17
		A 1933	Halle allester	Carl H				

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		ENT OF HEALTH AND	MENTAL HYGIEN		
	1. DECEOENT'S NAME (First, Middle, Last)				2. OATE OF OEATH		3. TIME OF DEATH
	THOMAS DOL	IGLAS LO	CKETI		June, I	9. 1995	
	1111 111 00-	/	rs. lest birthday) IF L	INDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. Bi	RTHPLACE (State or Foreign
	100 100112	M 2 0 F 5	YRS.	THE PROPERTY OF THE PARTY OF TH	Feb 16, 19	738	Va
<u>ر</u>	9e. FACILITY NAME (If not institution, give stree	t end number)	96.	CITY, TOWN OR LOCATION OF E	DEATH	9c. COUNTY O	
[	RESIDENCE OF DECEDENT	21 tol		Daltimore			NA
DIRECTOR	10e. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY LIMITS?
	Md	NA	Bal	Imore			1 YES 2 NO
FUNERAL	100. STREET AND NUMBER	e Streat		10f. ZIP CODE 2/2/23	3	10g. CITIZEN (	F WHAT COUNTRY?
5	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.	S. ARMEO	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	6 or No — 14. R	ACE — American Indian,
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES 2		If yes, specify Cuban, Mexic			lack, White, etc.
	15. DECEDENT'S EDUCAT	TION 100					Black
COMPLETED	(Specify only highest grade cor	mpleted)	DECEDENT'S USUA     (Give kind of work of     life. Do NOT use retire	lone during most of working	16b, KIND OF BU	SINESS/INDUSTR	Y
립	Elementery/Secondary (0-12)	College (1-4 or 5+) <i>N A</i>	Maint	unance	Chei	nical	Co
8	17. FATHER'S NAME (First, Middle, Last)		TVC COIN I	T. FILLY	AME (First, Middle, Melder	Sumeme)	
ш	Elisha T. Loc	Kett		Helen	B. To	ate	
TO B	190. INFORMANT'S NAME (Type/Print)	17 11	196. MAILING ADD	RESS (Street and Number or Rural	Route Number, City or Tox	vn, State, Zip Code,	,
-	Mary Lihoc	Kett	10 N	. Monrue ST	reet D	2/10/10/10	2/223
	20a. METHOD OF DISPOSITION  1 M Burlai 2 Cremetion 3 Ramova	I from State 20b. P.L.	ACEAND DATE OF DIS	SPOSITION (Name of	1 1/1/ 1. (4/	CATION — City o	Town, State
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICEN		ing 1	22. NAME AND ADDRESS OF F	- 1/23/95 PC	naalls	town ro
	Yola (	Marci		Majsh F. H	west 1	Walla.	Bo Ho Wed ZIZIC
	23. PART i. Enter the diseases, or con shock, or heart feliure. Lis	nplications that caused th	e deeth. Do not e	nter the mode of dying, such	ch as cardlec or reep	iratory arrest,	Approximate
	IMMEDIATE CAUSE (Final	a de stratega e se	-		1.0		Onset and Death
	disease or condition resulting in death)	SUAMOUS	CANCER	L OF LAF	MX		
		OUE TO (OR AS A CO	INSEQUENCE OF):				
NO	Sequentially list conditiona, b.	DUE TO (OR AS A CO	INSECTION OF OF				_
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	INSEQUENCE OF):				
IFICATION	if any, leading to immediate	DUE TO (OR AS A CO					
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury						
- CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST	DUE TO (OR AS A CO	INSEQUENCE OF):	a underlying pause pluse l	Don't Low was a		
AL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST  PART II. Other eignificent conditions of	DUE TO (OR AS A CO	INSEQUENCE OF):	e underlying cause given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMMERCIAN OF CAUSE
AL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in deeth) LAST	DUE TO (OR AS A CO	INSEQUENCE OF):	e underlying cauee given in		RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the conditions of the cause of th	DUE TO (OR AS A CO	not resulting in th		PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
AL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the perfect of the	DUE TO (OR AS A CO	not resulting in th	Q_NO □ UNCERTAI	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of HYPENTENS on DID TOBACCO USE CONTRIES.  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS A CO	not resulting in the DEATH YES PLACE OF DEATH (C)	NO UNCERTAL	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO	not resulting in the DEATH YES DEATH (C) The 3 DOA 1	UNCERTAL  Deck only one)  HER:  Nursing Home 5   Residence	PERFO	RMED?	ARABABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reauting in deeth) LAST  PART II. Other eignificent conditions of the cond	DUE TO (OR AS A CO	not resulting in the place of Death (C)	UNCERTAL  Nuck only one)  HER:  Nursing Home 5  Residence	PERFO 1 YES:	RMED?	ARABABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO	DEATH YES DEATH (CITY OF MALE OF DEATH (CITY OF DEA	DO UNCERTAL  seck only one)  HER: Nursing Home 5 Gesidence  286. INJURY AT WORK?  1 GYES 2 GNO	PERFO  1 YES  6 Other (Specify)  26d. DESCRIBE HOW  28f. LOCATION (Street	RMED?  2 KL NO  INJURY OCCURED  and Number or Rur	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO	DEATH YES DEATH (C)  The suiting in the suiting ind	UNCERTAI  Beck only one)  HER:  Nursing Home 5   Residence  28c. INJURY AT WORK?  1   YES 2   NO  1sctory, office	6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Yown, State)	RMED?  2 M NO  INJURY OCCURED  and Number or Rur	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO CONTRIBUTING TO GET TO CAUSE OF E  28.	DEATH YES DEATH (C)  PLACE OF DEATH (C)  29b. TIME OF INJURY  At homa, farm, street,	DO UNCERTAL  Note that the state of the stat	PERFO  1 YES:  N D 1 YES:  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State)	INJURY OCCURED	ARABABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO CONTRIBUTING TO GET TO CAUSE OF E  28.	DEATH YES DEATH (C)  PLACE OF DEATH (C)  29b. TIME OF INJURY  At homa, farm, street,	UNCERTAI  Beck only one)  HER:  Nursing Home 5   Residence  28c. INJURY AT WORK?  1   YES 2   NO  1sctory, office	PERFO  1 YES:  N D 1 YES:  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State)	INJURY OCCURED	ARABABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO CONTRIBUTING TO GET TO CAUSE OF E  28.	DEATH YES DEATH (C)  PLACE OF DEATH (C)  29b. TIME OF INJURY  At homa, farm, street,	DO UNCERTAL  Note that the state of the stat	PERFO  1 YES  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State)  a to the cause(a) end mage time, date end place, as	INJURY OCCURED and Number or Rui	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 VES 2 NO  NO PRIOR NUMBER,  NO PR
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO	DEATH YES DEATH (C)  29b. TIME OF INJURY  At home, ferm, etreet,  e, death occurred at 1  d/or investigation, in	DO UNCERTAL  seck only one)  HER:  Nursing Home 5   Residence  28c. INJURY AT WORK?  1   YES 2   NO  1actory, office  1   No office  29c. LICENSE NU	PERFO  1 YES  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State)  a to the cause(a) end mage time, date end place, as	INJURY OCCURED and Number or Rur nner as stated.	ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 VES 2 NO  NO PRIOR NUMBER,  NO PR
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  PART II. Other eignificent conditions of the con	DUE TO (OR AS A CO CONTributing to deeth but of ANC CE)  BUTE TO CAUSE OF II  28. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY — building, stc. (Specify)  N: To the best of my knowledge on the basis of examination and the complete of the cours	DEATH YES DEATH (CITEM 27) (Type, Print)	DO UNCERTAL  Neck only one)  HER:  Nursing Home 5   Residence  28c. INJURY AT WORK?  1   YES 2   NO  1actory, office  the time, dete end place, and during opinion, death occured at the	PERFO  1 YES  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State) a to the cause(a) end mage time, date end place, as	INJURY OCCURED and Number or Rui nner as stated. and due to the cause 29d. DATE SIGN	ARILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  Ref Route Number,  De(s) end menner as stated.



DIVISION OF VITAL RECORDS, P.O. BOX 68760

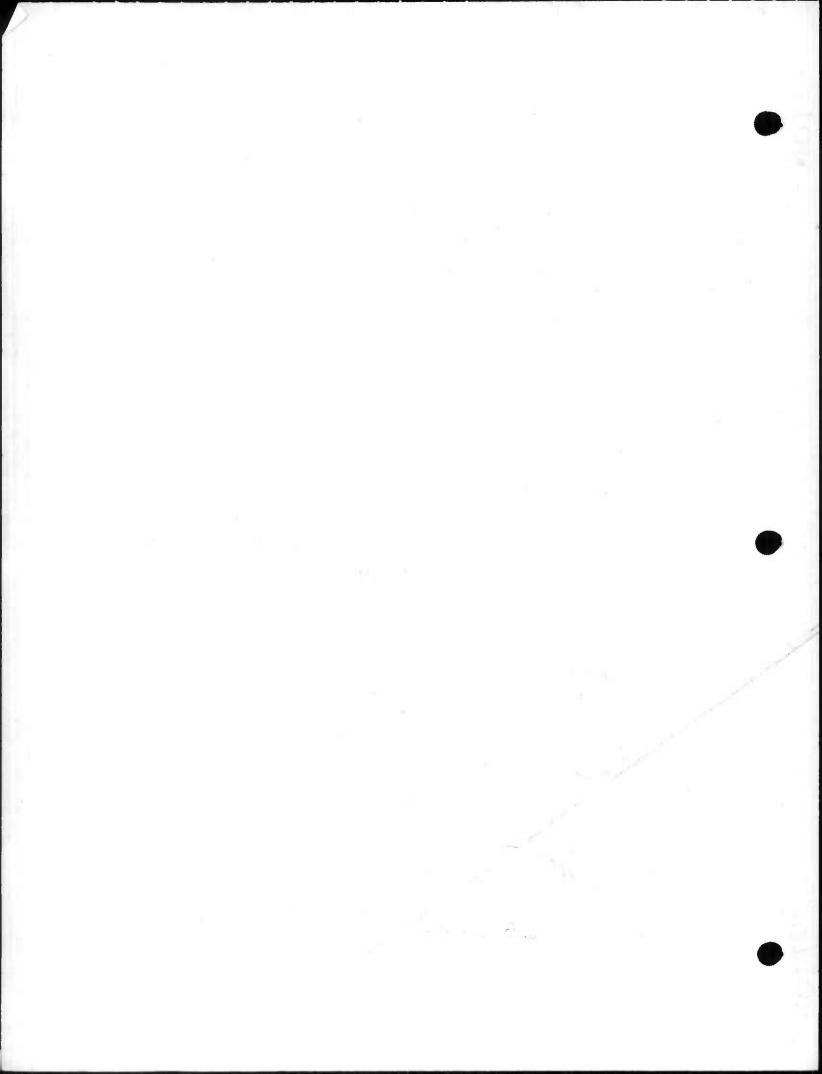
TO THE FUNERAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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JUN 2 3 1995

						95	18901
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	Laurens	0	Madia	2. DATE OF DEATN		SAR 3. TIME OF DEATH
	4, SOCIAL SECURITY NUMBER		(In yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	9, 179.	BIRTNPLACE (State or Foreign Country)
œ	9a. FACILITY NAME (If not institution, give	street end number)		b. CITY, TOWN OR LOCATION OF	OCT 2, 19		OF DEATH
DIRECTOR	PRESIDENCE OF DECEDENT  100. STATE  10b. COUNT	7	1.4.	Baltimore		1	)A
	Md	NA	Ba	1 (4 more			10d, INSIDE CITY LIMITS?  1 YES 2 NO
FUNERAL	916 Bridge	view Road	P	101. ZIP CODE	-	10g. CITIZEI	N OF WHAT COUNTRY?
	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	0 🗆 110	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 NO Spec	cen, Puerto Rican, etc.)	s or No — 14	. RACE — American Indian, Black, White, etc.
ED BY	3 Wildowed 4 Divorced  15. DECEDENT'S EDU (Specify only highest grade	CATION	11- 19-45	UAL OCCUPATION	16b. KIND OF BU	SINESS/INDUS	Black
once.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use n	done during most of working stired.)	Cons	trouses	tion
at once.	17. FATHER'S NAME (First, Middle, Lest)		day of the		AME (First, Middle, Melden	Surname)	[101]
TO BE	19e, INFORMANT'S NAME (Type/Print)		19b. MAILING AC	DORESS (Street end Number or Rura	Poute Number, City or Tow	m, State, Zip Co	ide)
9	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem	noval from State	PLACE AND DATE OF the Property, crematory or other	COCKTOSE A	Me Pare 200, LO	CATION - CIT	2/2/5 or Town, State
iner m	4 Donetion 6 □ Other (Specify) □ 21. SIGNATURE OF FUNERAL SERVICE LI	(v	arrison	22. NAME AND ADDRESS OF F	ACILITY, +	lings	MIlls, Hd
medical examiner must	( ) Dala	Marc	h	Mary F. H	Wabasi	a fre	- Bankud
	23. PART I. Enter the diseasea, or ahock, or heart fellure.  IMMEDIATE CAUSE (Final	complications that cause List only one cause on a	ech line.		0	ratory arrest	Approximata Interval Between Onset and Death
event, the	disease or condition resulting in death)	eDUE TO (OR AS A	CONSEQUENCE OF):	Myoundin!	Exerction		
49 1	Sequentially list conditions, If any, leading to immediate	bDUE TO (OR AS A	CONSEQUENCE OF):	<b>D</b>			
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated eventa	cDUE TO (OR AS A	CONSEQUENCE OF):				
P E	resulting in death) LAST	d					
DICAL C	PART II. Other algnificant condition	a contributing to death b	ut not reaulting in t	he underlying cause given in	PERFOR	MED3	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
ME	CAF	DIDLITE TO CALLET			1 D YES 2	ED NO	OF GEATN?
r item 23 s	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATN (		N L		
5 >	1 YES 2 NO 27. MANNEB OF DEATN	1 Inpetient 2 ER/Outp 26e, DATE OF INJURY (Month, Day, Year)		F 28c. INJURY AT	6 Other (Specify)  26d. DESCRIBE NOW I	NJURY OCCUR	EO
Is marked, D BY PH	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could pat be	28e. PLACE OF INJURY	At home, ferm, street	M 1 YES 2 NO	28f. LOCATION (Street of	and Number or I	Rural Route Number,
lem 28 LETE	4 Homicide determined	building, atc. (Spec	ony)		City or Town, State)		
=   =	(Check only			t the time, data end place, end du n my opinion, death occured at the			suse(e) and manner as stated.
BE	29b. SIGNATURE AND TITLE	~	MD	29c. LICENSE NU	IMBER	29d. DATE SI	GNED (Month, Day, Year)
₹ 0	30. NAME AND ADDRESS OF ASISON WH	O COMPLETED ONUSE OF DE	ATN (ITEM 27) (Type, Pri	777 6:10	to	1 4	771 17
	31. DATE FILEO (Month, Day, Your)	L. PARESET ARE SEN	THE STATE OF THE S	1 Justa	3 Jun K	az	(6)

DNMN-16 Rev 1/89



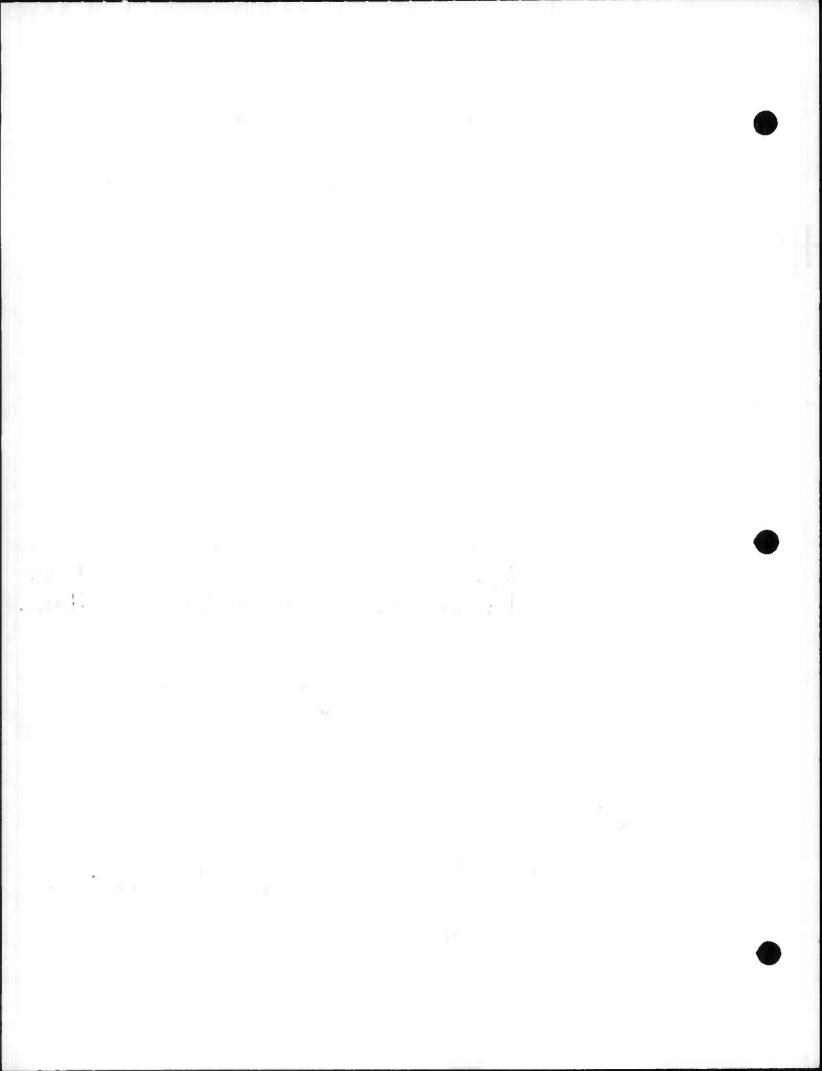
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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE

	REGISTRAR	_		C	ERITE	ICATE	OF	DEAT	Н	RI	EG. NO.			
	1. DECEDENT'S NAME (First, Susan	Middle, Last)	Patric	ia		Muti	h			Julie	22°	,1995	YEAR	3. TIME OF DEATH 7:45a
	4. SOCIAL SECURITY NUMB	IF UNDER 1	YEAR	YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH				B. BIRTHPLACE (State or Foreign						
	213- <b>5</b> 0-6439		1 🗌 M 2 💢 F	6. AGE (In yrs. Ia 43	YRS.		DAYS	HOURS	MIN.	Feb. 2	Year)	1952	Countr	yland
_	9e. FACILITY NAME (If not ins					9b. CITY,	TOWN OF	R LOCATION	N OF DEA	ATH		9c. COUR	NTY OF D	DEATH
DIRECTOR	Greater Baltimore Medical Center							n				В	alti	imore
8	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN OF	R LOCATIO	ON						10d. INSIDE CITY
	Maryland  10a. STREET AND NUMBER	Baltin	nore		Tin	onium	_	320						1 YES 2 NO
FUNERAL	101 Gorsuch	Road						21P CODE 1093						States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. W	AS DECE	NDENT OF	HISPANI	C ORIGIN? (Sp	ecify Yes	or No-	14. RACE	E — American Indian,
BY	1 Never Married 2 🔀 1 3 Wildowed 4 Divor	IF YES GIVE WAR OR DATES												
E	15. DECE (Specify only	DENT'S EDUCA	ATION			USUAL OCC				16b. KIND	OF BUS	INESS/IND	USTRY	
<u></u>	Elementery/Secondary (0-	1	College (1-4 or 5 +	- His	Do NOT us	work done du se retired.)	unng most	t or working	,					
COMPLETED			2	Tra	anscr	iptic	nis	t		Med	ical			
8	17. FATHER'S NAME (First, MIC Charles Frai		mle							E (First, Middle				
BE	190. INFORMANT'S NAME (T)		шк	140	b. MAN 1940	40000000				quelir			3	
5	John C. Mutl									nium, M				3
	20e, METHOD OF DISPOSITION		-14	20b. PLACE	AND DATE	OF DISPOSIT					_	CATION —	_	
	4 Donation 5 Other	(Specify)		St. M	amatory or o	ther place) Ceme	eter	У		6/24	Bal	timo	re,	Maryland
	21. SIGNATURE OF TOWERAL	SERVICE LICE	NSEE CH	_	_			ADDRESS		efeld ]	IIomo	Т		
	Stev	le (.	Sum	>		65	00	York	Road	l Balt	imor	e. Ma	c. arvl	and 21212
	23. PART i. Enter the dis	seasea, or co	emplications the	ceused the de	eth. Do r	not enter t	he mod	e of dyln	g, auch	aa cardlec d	or respi	ratory arr	eat,	Approximata
	IMMEDIATE CAUSE (Fine		at only one ceu	se on eech line	Э.	-			, /	100				Interval Batween Onset and Death
	disease or condition resulting in death)	<b>+</b>	tur	gal:	500	515	> (	M	21	TKD.	5			Stam
			ONE TO	OR A CONSE	DUENCE	00	n.v	10	nla	ata	1/4	~	_	Time
ON	Sequantially list condition		101	waru	1 +	pl	)WK	7	UK	20101	11	זטו	}	TAMO
¥ I	if any, leading to immed cause. Enter UNDERLYIN	VG	Mo	FP	00	ica	0	tic		Ca				11 mg
	CAUSE (Disease or injur that initiated events	у 🔓 с.	OUE TO	OR AS A CONSE	OUENCE OF	F):						-		1
CERTIFICATION	reaulting in death) LAST	ď.				9								
	PART II. Other significan	nt conditions	contributing to	deeth but not i	resulting	in the und	lertving	ceuse alv	ven in P	art i. 24a	WAS AN	MITOPSY	245	. WERE AUTOPSY FINDINGS
EDICAL			_				, , ,				PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								/		_   ''	YES 2	PHO		OF DEATH?
∑ ;;	DID TOBACCO US	E CONTRI	BUTE TO CA	USE OF DEA	TH YE	S 🗆 N	ó M	UNCE	RTAIN					1 YES 2 NO
₹ I	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PLAC	E OF DEAT	H (Check on								
Sic	1 YES 2 NO	!	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 Real	idence 8	Other (Spe	clfv)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, Da	INJURY	20b. TIM		8c. INJUI	RY AT		2ad. DEŞCRIBI		JURY OCC	UREO	
BY		ending rvestigation		y, roury	1145	М		S 2   1	NO					
ED	3 Suicide 6 C	could not be	28e. PLACE OF building,	INJURY — At he	me, term, s	dreet, fector	y, office		-	281. LOCATION City or Tow	(Street e	nd Number	or Rural R	loute Number,
	4 Homicide	etermined								Only or row	n, otelo)			
립	29e. CERTIFIER CERTIFIER	FYING PHYSICI	AN: To the best of	my knowledge, de	ath occurre	ed at the tim	e, date e	nd place, e	end due to	the ceuse(e)	end man	ner ee state	ıd.	
COMPLET	one)	CAL EXAMINER:	On the beele of ex	amination and/or	investigatio	n, in my opi	inion, des	ith occured	d at the ti	me, date end p	lace, end	due to the	e ceuse(s	) and manner es stated,
BE 0	29b. SIGNATURE AND TITLE	OF CENTIFIER	1/0.	1				29c, LICENS	ISE NUMB	ER		29d. DATE	SIGNED	(Month, Day, Year)
						72/95/								
임	30. NAME AND ADDRESS OF										-			
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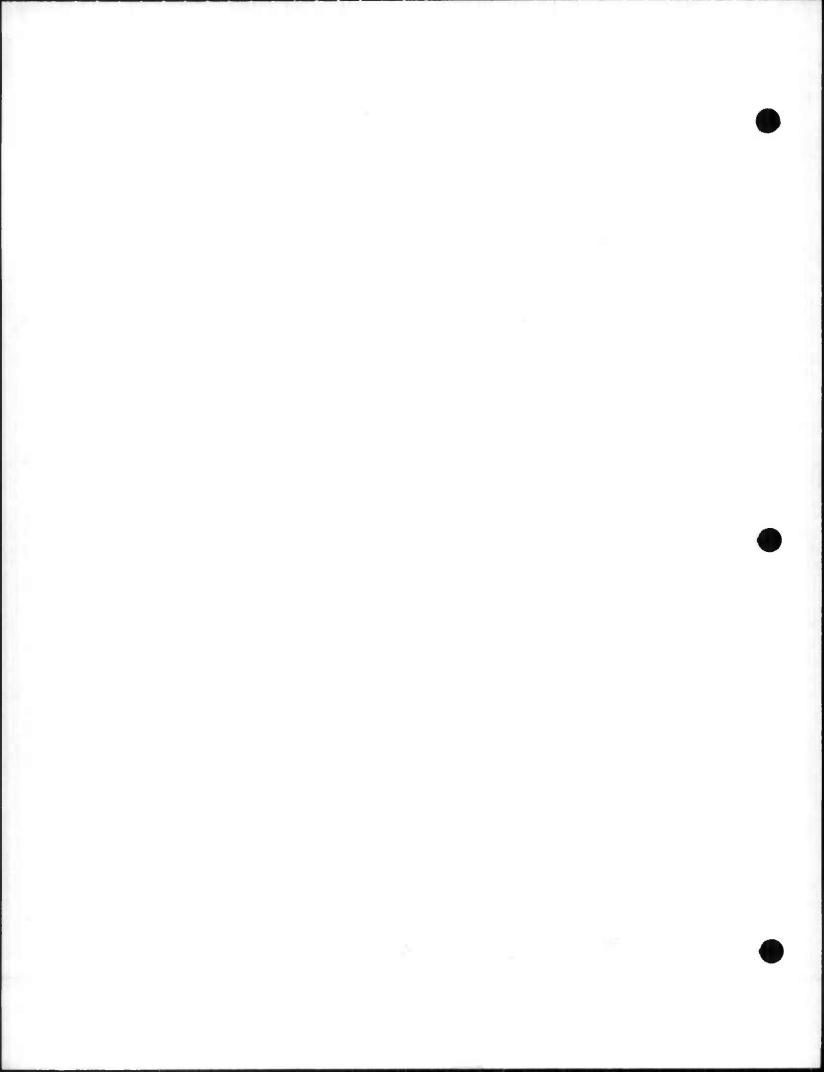
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		ENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)	IARY (	DATE	5		2. DATE OF DEATH DA	Q YEAR	1 WIME OF DEATH 20
	4. SOCIAL SECURITY NUMBER 214-01-9089		E (In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN	7. DATE OF BIRTH (Month, Day, Year) Dec 31, 1	Count	HPLACE (State or Foreign ny) aryland
Œ	9a. FACILITY NAME (If not institution, give streets) 9501 Perry Broo	set and number)			IR LOCATION OF DEA		9c. COUNTY OF D	DEATH
DIRECTOR	RESIDENCE OF DECEDENT  104. STATE  10b. COUNTY	- Court					Daitimo	16 00
	Maryland Ba	ltimore		timore	ION			10d. INSIDE CITY LIMITS?  1 YES 2X NO
FUNERAL	10e. STREET AND NUMBER 9501 Perry Br	ook Court		101	21236		10g. CITIZEN OF V	
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 24-NO	If yes, spi	ENDENT OF HISPANIC lefty Cuben, Maxican, 2 NO Specify:	ORIGIN? (Specify Yea Puerto Rican, etc.)	Black	E — American Indian, k, Whita, etc.  White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)	18a, DECEDENT'S (Give kind of w life. Do NOT use	ork done during mo:	N st of working	16b, KIND OF BUS		
MP	17. FATHER'S NAME (First, Middle, Lest)		Homen	naker		Own H		
	Charles Henry	Wolverton				E (First, Middle, Meiden : orence Br		
TO BE	19a. INFORMANT'S NAME (Type/Print)		T T		nd Number or Rural Ro	ute Number, City or Town	n, State, Zip Code)	
-	Sharon Wright 200. METHOD OF DISPOSITION					t, Baltim		
	*XX Burial 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	ral from State	ob. PLACE AND DATE Of the period of the peri	rdisposition(Na berplace) Lemetery	me of		timore,	
	21. SIGNATURE OF FUNERAL SERVICE LICE		)	22. NAME AN	D ADDRESS OF FACIL	LITY		
	1. Blan	Seits!	11	3818 R	oland Ave	Jr. Fune	imore M.	
	23. PART i. Enter the diseeses, or co shock, or heart failure. Li	mplications that caus ist only one cause on	ed the death. Do no each lina.	ot enter the mod	de of dying, auch	as cerdiac or reapir	ratory arrest,	Approximata interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Cho (ANG LO CANC L NOM A)  DUE TO (OR AS A CONSEQUENCE OF):							
z	METASTATIC							
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS	A CONSEQUENCE OF	):			· · · · · · · · · · · · · · · · · · ·	
CERTIFICATION	CAUSE (Disease or injury that initiated evants	OUE TO (OR AS	A CONSEQUENCE OF	);				
CER	resulting in death) LAST							
AL	PART ii. Other aignificant conditions	contributing to deeth	but not resulting in	the underlying	cause given in Pa	ert i. 24a. WAS AN A		. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
PHYSICIAN: MEDIC						1 TYES 2	₩ NO	OF DEATH?
N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH YES	5 🗆 NO 🗆	UNCERTAIN			1 TES 2 NO
ICIA		HOSPITAL:		OTHER:				
HYS	1 VES 2 NO  27. MANNER OF DEATH	1 Inpetient 2 ER/Ou 25a. DATE OF INJURY	26b. TIME	OF 28c. INJL	5 Residence 6	Other (Specify)	JURY OCCURED	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		RK? ES 2 NO	,		
0	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUF building, etc. (Sp	RY — At home, larm, st ecify)	reet, factory, office	2	81. LOCATION (Street ar City or Town, State)	nd Number or Rural R	Poute Number,
COMPLET	29a. CERTIFIER (Check only one)							
BE CO	2 MEDICAL EXAMINER:		on and your garden	, in my opinion, de	29c. LICENSE NUMBI		29d. DATE SIGNED	
TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	/m /	M	D259	110	6/2	3/25
	JOHN A. Cor	INGTON	run, s	VITE 40	18 650	STN.C	LARLES	St Parson
	31. DATE FILEO (MONTH, Day, Year)  JUN 2 3 1995	32. REGISTRAR'S SIG	NATURE					
	JUN 6 5 1333	I HILLY DELLE	MAC Addall					



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the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physis	r the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria	
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within	pietely	d Mental Hygiene prior to burial, cremation, or rer
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)
JUN 2 3 1995

TO BE COMPLETED BY FUNERAL DIRECTOR

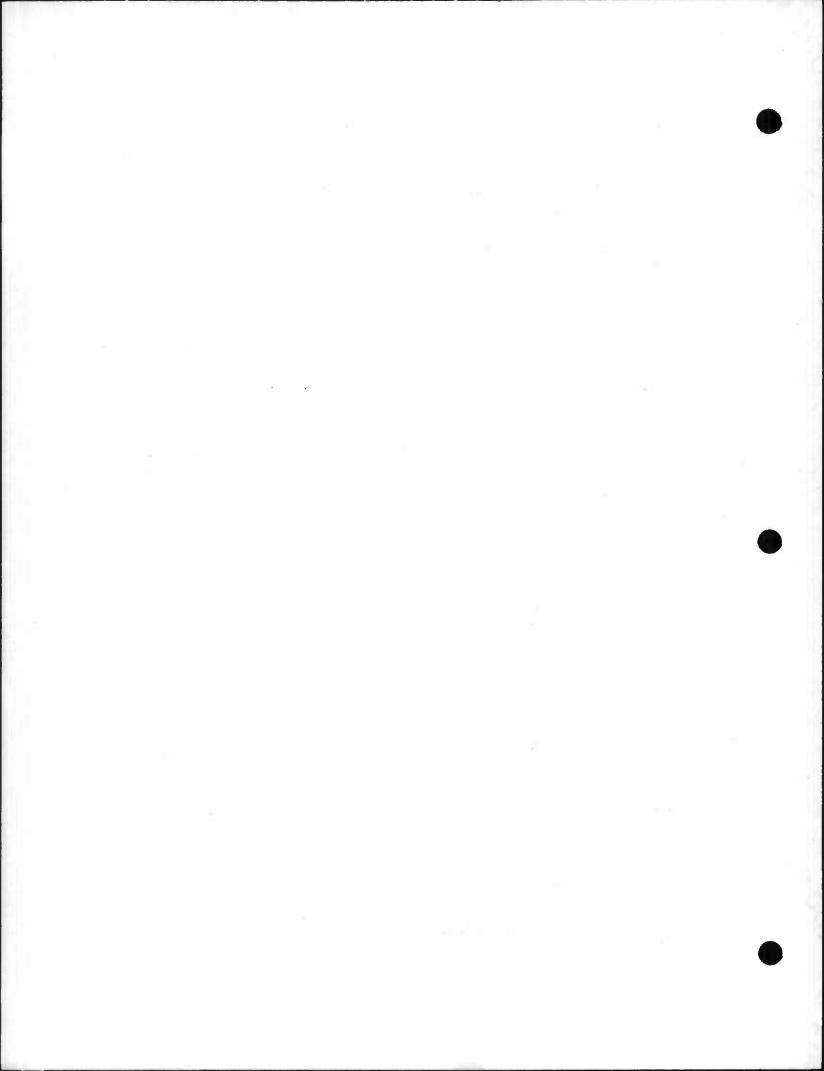
I-transit permit, Pages 1, 2, 3 should ician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR 1 STATE		STATE OF	MARYL						MENTA	L HYGIEN	IE .			
REGISTRAR				CE	RTIF	ICATE	OF DE	ATH		REG. NO	).			_
1. DECEDENT'S NAME (First	, Middle, Last)									OF DEATH	MY	YEAR	3. TIME OF D	EATN
MICHAEL		0				0	'NEAI		JUI	VE 15	, 19	995	8:20	Ам
4. SOCIAL SECURITY NUMBER	BER	5. SEX		(In yrs. last		IF UNDER 1 Y	EAR IF UN	IDER 24 HRS.	(Monti	OF BIRTN h, Day, Year)		Count	HPLACE (State o	
UNKNOWN		1 💢 M 2 🗆 F	33		YRS.	TOWN TO	ATS HOOF	is min.	3/2	5/1962	2	BAL	TIMORE	,MD.
90. FACILITY NAME (If not in	stitution, give s	treet end number)				96. CITY, TO	WN OR LOC	ATION OF O	EATH		9c. CO	UNTY OF E	DEATN	
JOHNS HO		HOSPIT	'AL			BALT	TIMOF	RE						
RESIDENCE OF DEC	10b. COUNT	,			10a CIT	V TOURI OR I	00471041							
MADYLAND CITY								10d. INSIDE C						
100. STREET AND NUMBER		T .			DA	LITMUR	T						1 NYES 2	
1915 N. PA		TDEET					10f. ZIP C						WHAT COUNTRY	n
1915 N. PA	120N 2		T 63/50 /				212				USF			
1 Never Merried 2	Married	12. WAS DECEDER FORCES?	YES	2 X N	O	If ye	s, specity C	uben, Mexica	an, Puerto I	l? (Specify Ye Ricen, etc.)	s or No-	14. RAC Blac	E — Americen I k, White, etc.	ndlen,
3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR C	DATES		1 🗆	YES 2 📉	NO Specif	fy:			BLA	CV	
	EOENT'S EDU			16a, DEC	CEDENT'S	USUAL OCCU	IPATION		166	KIND OF BU	SINESS /IA		ICK .	
	y highest grade	completed) Cotlege (1-4 or 5	.)	(Gh	ne kind of a Do NOT us	work done durli	ng most of we	orking	"		0111200711	10001111		
Elementary/Secondary (1	- · · · ·	0	+)	H	EALT	H CARE	WORK	ER		SELF-	<b>EMPL</b>	OYME	NT	
17. FATNER'S NAME (First, M	liddle, Last)						18, M	OTNER'S NA	ME (First, I	Middle, Meiden	Sumemel	-		
FRANK S	. 0"N	FAL						OYCE		NNER	O"NE	-A1		
19e. INFORMANT'S NAME (				19b.	MAILING	ADDRESS (SI								
JOYCE S.	O"NEAL												AND 213	217
20a. METHOD OF DISPOSIT	ION		200	. PLACEA	NDDATE	OF DISPOSITIO	N (Name of		DAT	E 20c, LC		- City or To		
1 X Burlet 2 Cremette 4 Donation 6 Other		oval from State	cer. K	TNG I	MEMO	RIAL P	ARK 6	/21/9	15	RANI		•	, MD.	
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE 6	0	->	TETTO	22. NAI	ME AND ADD	RESS OF FA	VOILITY	- INTITE	, LLL	Onito	, 110.	
Not on	// h	, 6th	Vo	/		EST	EP BR	OTHER	RS FU	NERAL	HOME	P.A	•	
		1 (1)	<u> </u>	<del>/</del>		130	O EUT	AW PL	ACE,	BALTI	MORE	, MD	. 2121	7
23. PART I. Enter the A shock, or h	eart failure.	List only one car	use on 6	the dea fach line.	ith. Do r	ot enter the	moda of	dying, suc	ch aa carc	llac or reap	iratory a	rreat,	Approx	Imata Between
IMMEDIATE CAUSE (Findisease or condition	nal	11	,,			,	1 1		0					end Death
resulting in death)	<b>→</b>	DUE TO	ulti	ple	64	ushu	11 6	Vous	nd 5	·				
		DUE TO	(OR A9	A CONSEO	UENCE O	F):								
Sequentially list condit	lona,	b	100.00	A CONSEC										
if any, leading to imme cause. Enter UNDERLY		002 10	(OH AS )	CONSEC	UENCE O	-):							İ	
CAUSE (Disease or inju		DUE TO	OR AS	A CONSEC	HENCE OF									
that initiated events reaulting in deeth) LAS	т	202.10	(=:			,							i	
		ſ,											1	
PART II. Other significa	nt condition	s contributing to	death b	out not re	sulting	n the under	lying ceus	e given in	Part I.	24s. WAS AN		246	. WERE AUTOPS	
										PERFOI			COMPLETION C	
													OF DEATH?	□ NO
DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE C	F DEAT	TH YE	S 🗆 NO	1U 🗆	NCERTAII	NO				X	
25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL			26. PLACE	OF DEAT	N (Check only	one)							-
1 X YES 2 NO		HOSPITAL:	ER/Out	patient 3 (	□ DOA	OTHER:	Home 5	Residence	6 ☐ Other	(Specify)				
27. MANNER OF OEATN		28e. DATE OF	INJURY		28b. TIM	E OF 286	. INJURY AT			CRIBE HOW	NJURY O	CCURED		_
	Pending Investigation	6-15-	95		404	URY 1	WORK?	NO	sui	bject	sho	of		
a D Cutate	Could not be	28e. PLACE C	F INJURY	— At hor	ne, term, s	treet, tectory,	office		281. LOC	ATION (Street	end Numbe	er or Rural J	Route Nymber,	1
	determined	bunding,	atc. (Spec		reel	_			Bal		1300	N. (	Poute Number	N V R
29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the best of	my know		,		data and al-	on and di-						-
		R: On the basie of e											and menne -	o stated
29b. SIGNATURE AND TITE					90.10	у орин				und prace; en				
LUC SIGNATURE AND THE		. 0 /	1	1			29c. l	ICENSE NUI					(Month, Day, Ye	
30. NAME AND ADDRESS OF	PERSON WAY	COMPLETED COM	aw,	1600	27.7	0-(-1)		0.C.	M.E.		JU	JNE	16, 19	995
OV. HAME AND ADDRESS OF	PERSON WIN	COMPLETED CAU	DE UF DE	AIN (ITEM	27) (Type,	Print)								

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Penn Street, Baltimore, Maryland 21201



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

1 -

3. TIME OF DEATN

10d. INSIDE CITY

WHITE

Approximate

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 NO

Day, Year) 95

Interval Between

**Onset and Death** 

Specify:

BURNS

1 YES 2 XNO

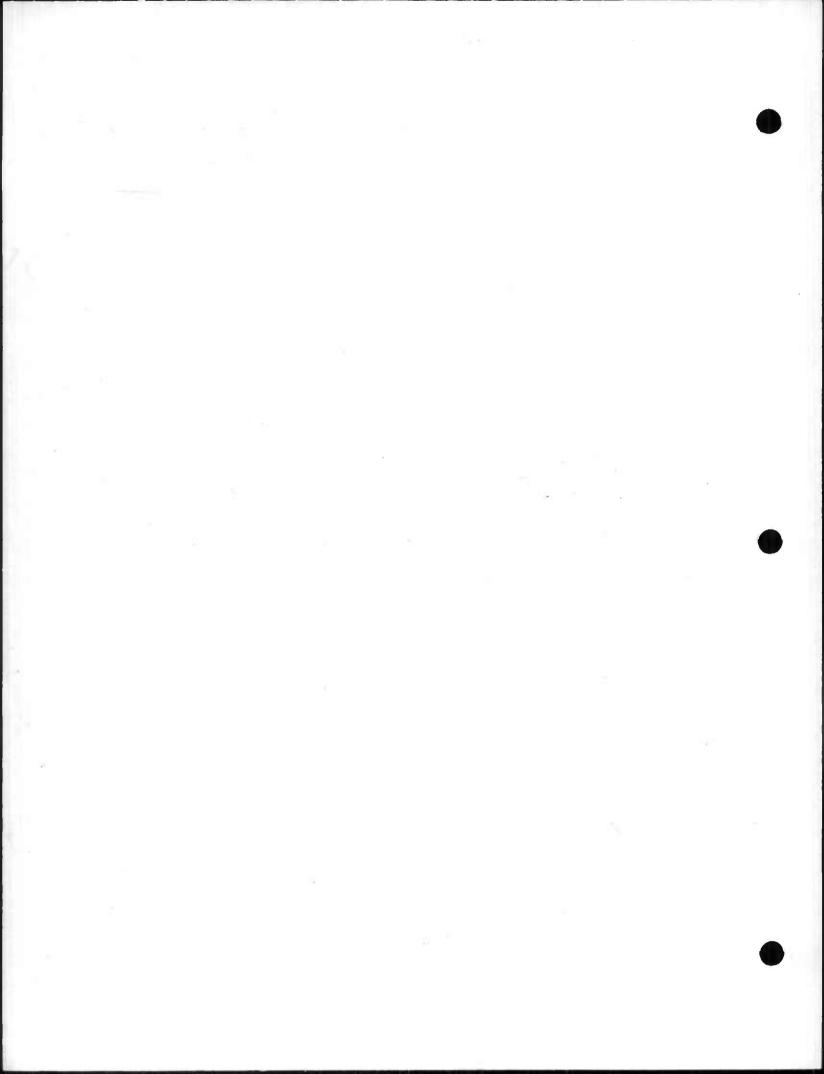
- 920PM

2. DATE OF DEATH

DATE OF B 1999 B. BIRTHPLACE (State or Foreign Country) DATE OF BIRTH (Month, Day, Year 068 -20-333 68 DAYS HOURS YRS November- 9,1926 Pannsylvania Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN Anne Arundel North Arundel Hos DIRECTOR Burnie Pages 1, 2, 3 MALU. RESIDENCE OF DECEDENT 10a STATE 105 COUNT 10c. CITY, TOWN DR LOCATION MARYLAND ANNE ARUNDEL GLEN BURNIE permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? competey fined in by the tuneral director, page 5 should be detached for use as the burial-transit 1 ELM DRIVE 21060 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 ND IF YES, GIVE WAR DR DATES 1 Never Married 2 X Married 1 YES 2 X NO Specify BY 3 Widowed 4 Divorced WW II COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) 12 YEARS YEARS PHARMACEUTICAL MEDICAL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surnama) F CHARLES FRANCIS PARLATO 8 CATHERINE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JACKIS PARLATO ELM DRIVE GLEN BURNIE, MARYLAND 21060 å 20e, METHOD OF DISPOSITION
1 & Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 ☐ Donation 8 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 6-24 GLEN BURNIE, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME hours after death. 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061 medical 23. PART L Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE Final H disease or condition unknown arcinoma resulting in death) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEDUENCE OF): specuted burlat, Iraumatic CERTIFICATION H Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF) B If any, leading to immediate cause. Enter UNDERLYING attending physician intal Hygiene prior to the death certificate be prior CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST ä Mentar A PART II. Other apprificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Health and eua Hear any t TYES 2 NO has been Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The the State tem HOSPITAL: **EXAMINER?** OTHER 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Realdence 8 ☐ Other (Specify) 6 27. MANNER OF DEATN 28a. DATE OF INJURY with & 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 X Natural 1 YES 2 NO BY After Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 66 3 Sulcide DIRECTOR: / 8 Could not be COMPLETED 4 Homicide 28 29e. CERTIFIER (Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DID BE filed within 72 his important: If it HOSPITAL 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Mont) BE MD 2 30. NAME AND ADDRESS OF ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) North Momode Alunda 407 0 JUN 2 3 1995

22. REGISTRAN'S SIGNATURE

DHMH-16 Rev 1/89

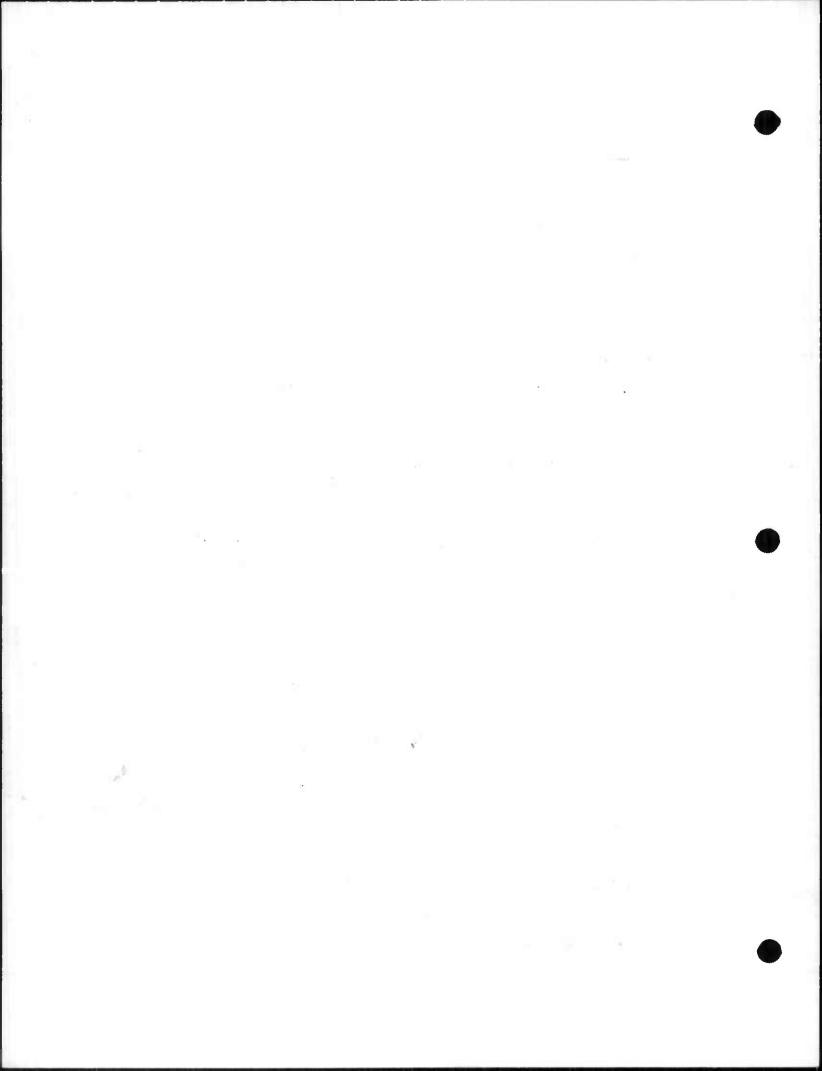


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DALLIMORE, MARILAND ZIZIO-0020	I hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

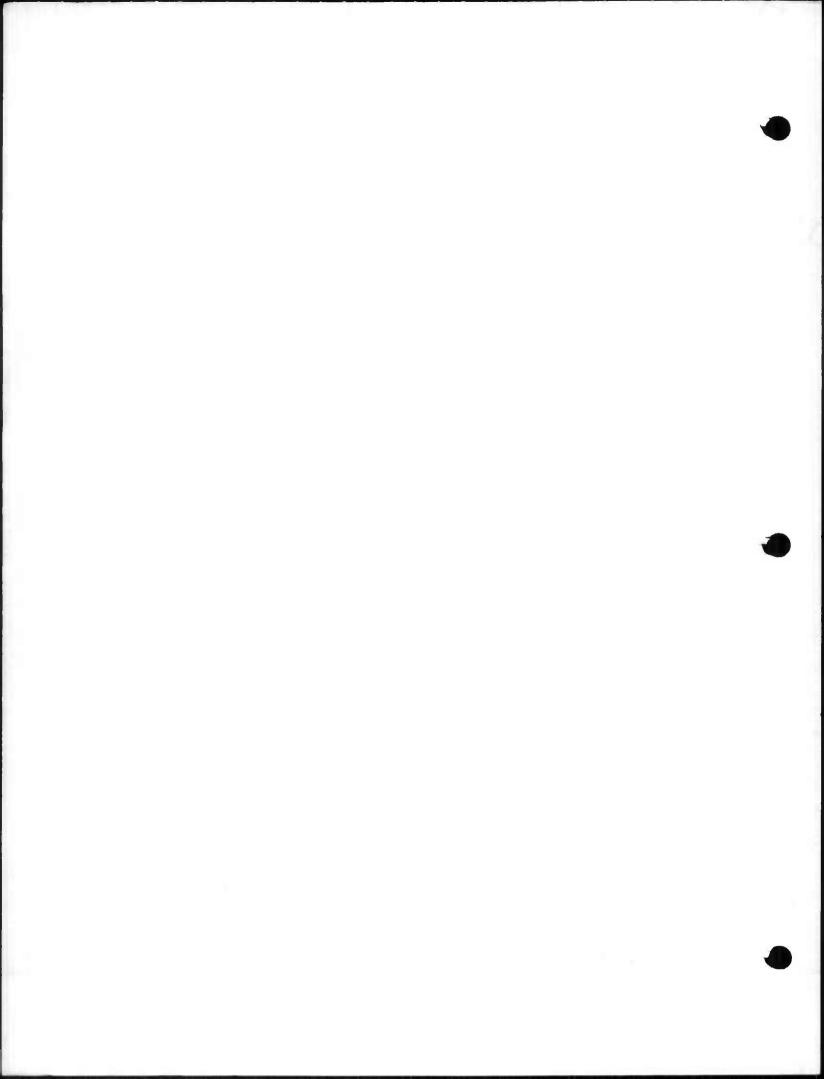
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT ICATE	OF HEAD	TH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN		3. TIME OF DEATN	
	JAMES D.	PATRYLAK		6 2	1 YEAT	5 3:38 a M				
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1	YEAR IF UP	IDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8, Bit	RTNPLACE (State or Foreign unitry)	
	1 1 1 2 - 2 4 - 0 3 9 9	1 XM 2 □ F 64	YRS.				March 7	,1931 P	ennsylvania	
œ	Sa. FACILITY NAME (If not institution, give atre				TOWN OR LOC	ATION OF D	EATH	9c. COUNTY O		
DIRECTOR	1003 Kenilworth	Dr.		То	wson			Balt	imore	
REC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OF	LOCATION				10d. INSIDE CITY	
	Maryland Balti	.more		Tows	on				1 YES 2 X NO	
3AL	10e. STREET AND NUMBER				10f. ZIP C	ODE		10g. CITIZEN O	F WHAT COUNTRY?	
FUNERAL	1003 Kenilwort					.204		U.S.	Α.	
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	U.S. ARMED	11	yes, specify C	uban, Mexico	NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.)	or No- 14. R/BI	ACE — American Indian, lack, White, atc.	
B≺	3 Wildowed 4 Divorced	Korea	TES	1	□ YES 2 🔀	NO Specif	fy:		ite	
COMPLETED	15. DECEDENT'S EDUC/ (Specify only highest grade of	ATION	16a. DECEDENT'S	USUAL OCC	CUPATION iring most of w	46.	16b. KIND OF BUS	SINESS/INDUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT us	e retired.)	ring most or wi	oriang				
MP	12 yrs		System	s An	alyst		U.S.	Govern	ment	
	17. FATHER'S NAME (First, Middle, Last)				18. M	OTHER'S NA	AME (First, Middle, Maiden	Sumame)		
BE	James Pa	trylak	T			lia		can		
2		. 4 1					Route Number, City or Tow			
	Elizabeth J. Pa	20h	PLACEAND DATE				TOWSON DATE 20G LO	MO CATION — City or	21204	
	1 Surial 2 Cremation 3 Removed Burnel 2 Cremation 3 Cher (Specify)	ral from State come	etery, crematory or o	ther place)	Θ37		6-24 Tir			
	21. SIGNATURE OF FUNERAL SERVICE LICE		-//		AME AND ADD	RESS OF FA		MOTTE CITI	, Mu.	
	· He a	166		Ru 10	ck To	wson	Funeral d. Towson	Home,	Inc. 21204	
	23. PART I. Enter the diseases, or co shock, or heart fallure. Li	mplications that caused	the death. Do n	ot enter t	he mode of	dying, suc	h as cardiac or reapi	ratory arrest,	Approximata	
	IMMEDIATE CAUSE (Final	2000		)		1	,		Interval Batween Onset and Death	
-	disease or condition resulting in death)	meta	STAT	77-	pro	STM	te CA	ncer	7 yrs	
		DUE TO (OR AS A	CONSEQUENCE OF	F):	/					
0 N	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):									
SAT	if any, leading to immediate cause. Enter UNDERLYING			,						
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	j:						
CERTIFICATION	resulting in death) LAST									
AL C	PART II. Other algolificant conditions	contributing to deeth bu	t not resulting i	n the und	arlying ceus	e given in	Part I. 24a. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS	
2						_	1   YES 2	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
							1 1 1 1 1 2	A	OF DEATH?	
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S 🗆 N	O X UI	CERTAI	N D			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEAT		* /					
YSI	1 YES 2 NO	1 Inpatient 2 ER/Outpa	tlant 3 🗆 DOA	OTHER:		Residence	8 Other (Specify)			
H	27. MANNER OF DEATN  Natural 5 Pending	(Month, Day, Year)	28b. TIMI INJ	E OF 2	8c. INJURY AT WORK?		28d. DEŞCRIBE HOW II	NJURY OCCURED		
B	2 Accident Investigation	DO DI ACE OF IN HUDI		M	1 TYES	NO NO				
COMPLETED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY - building, stc. (Specif	— At home, larm, a (y)	treet, lactor	y, affice		281. LOCATION (Street a City or Town, State)	ind Number or Run	al Route Number,	
91	290. CERTIFIER	AN: To the heat of my knowle	4. 4. 1			`				
MP		AN: To the best of my knowle On the beale of examination							helps an annum has (a)	
	29b. SIGNATURE AND TITLE OF CRATIFIER		) m			ICENSE NUI				
B	USL. Ant	Lany K	Cilou	M	DIT	25		▶ 6/=	ED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED ONUSE OF DEA	TN (ITEM 27) (7/pe,	Print)	U			-/-	110	
	Dr. Anthony R	iley 6565	N. Cha	rles	St.	Tows	on, Md. 2	21204		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE							
	JUN 2 3 1995	Jalia Davidson-	randall							



	1
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90,	within
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	AT DR ATTENDING PHYSICIAN. The law requires that the death certificate he executed within
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DATE OF THE COLDS, F.O. BOX 99/90, BALLIMONE, MANTEAND 21219-0020	HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 widors after death. Page 6 may be retained by the hospital or attending physician.		led within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	RANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
-	TO THE H	TO THE FI	be filed w	IMPORT	

	1 - FOR STATE OF I	MARYLAND /	DEPARTM ERTIFICA	ENT OF H	EALTH DEAT	AND ME	NTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Lest)  Beatrice Marie Ryne					_	DATE OF DEATH	AY	YEAR 3. TIME OF PEATR		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. les	birthday) IF	UNDER 1 YEAR	IF UNDER 2	24 HRS. 7.	DATE OF BIRTH	1 19	B. BIRTNPLACE (State or Foreign		
	218-28-5519 1□M2⊠F	63		THE DAYS	HOURS	MIN. S	ept. 10, 1	931	Maryland		
œ	98. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b.	CITY, TOWN O		N OF DEATH		9c. COUNT	Y OF DEATH		
210	RESIDENCE OF DECEDENT			Ва	ltimo	re		Ва	ltimore		
- DIRECTOR	Maryland Baltimore  100. STREET AND NUMBER		10c. CITY, TO		edale				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ERA	7926 31st Street			101.	ZIP CODE 212	37		-	S.A.		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 3 Wildowed 4 Divorced IF YES, GIVE W	T EVER IN U.S. AR YES 2 X N AR OR OATES	MED IO	If yes, spe	ENDENT OF city Cuben, 2 NO	, Mexican, P	ORIGIN? (Specify Yes werte Rican, etc.)	or No — 1	4. RACE — American Indian, Black, Whits, etc. Specify: White		
COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)	(G	CEDENT'S USU We kind of work of Do NOT use reti	done durina mas	N it of working		16b. KIND OF BUS	BINESS/INDU	STRY		
MP.	12th grade Cottege (1-4 or 5-	.)	Secreta	,			Steel a	nd Tir	n Can Company		
	17. FATHER'S NAME (First, Middle, Last)  Edward J. Urban						(First, Middle, Malden				
BE	19a. INFORMANT'S NAME (Type/Print)	191	. MAILING ADD	RESS (Street ar		na K	. Huran		Cordel		
2	Frederick J. Rynes (husba	nd)	7926 3	31st Sa	treet	, Bal	timore,	MD 21	1237		
	20e. METNOD OF DISPOSITION 1/\(\alpha\) Burlet 2 \(\subseteq\) Cremetion 3 \(\subseteq\) Removal from State 4 \(\subseteq\) Donation 5 \(\subseteq\) Other (Specify)	20b. PLACE A correctory, case GOLA	matory or other p	SPOSITION (Name)	Como	toru	0ATE 20c. LO	cation - ch	ty or Town, State 2, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	<i>(</i>		22. NAME AN	D AODRESS	OF FACILI	TY OHAR Ham	ou Tu	e, margrana		
	1 / laster of / Al	~		9705	Bel	air R	d., Balt	imore,	nc. MD 21236		
	23. PART I. Enter the diseases, or complicisions that ceused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, and anock, or heart fellure. List only one ceuse on sech lins.  IMMEDIATE CAUSE (Finsi disease or condition resulting in death)  a. The first leave lea										
ON ON	Sequentieily list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):										
CAT	CAUSE (Disease or Injury										
CERTIFICATION	that initiated events resulting in death) LAST	(OR AS A CONSEC	UENCE OF):								
L CE	PART II. Other significant conditions contributing to	death but not n	euiting in th	e underlying	ceuse ob	ven in Per	1 1 240 MM CAN	ALITOREY	24b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICA	PERFORMED?  1 YES 2 NO OF								AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:				CE OF OE	ATH (Check o	only one)				
1XSI	1 YES 2 NO 1 Inpatient 2		□ DOA 4 □				Other (Specify)				
ВУ РР	1 Pending (Month, Da		28b. TIME OF INJURY	M 1 Y	RK?		d. DESCRIBE NOW II	HURY OCCU	REO		
	2 Accident investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Street and Number or Rural Route Number, City or Town, Street								Rurel Route Number,		
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFYING PNYSICIAN: To the best of 2										
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER		00	0	29c. LICEN	SE NUMBER	100	29d. DATE S	SIGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	E OF DEATH (ITEM	27) (Type, Print,	W	00	-111	15011	6	-22-93		
	Marles F.OI)	NAC	111	MI)-	-11	145	in let 8	4111	2/2/210		
	31. DATE FILED (Month, Day, Your) 32. REGISTRAL SGE										



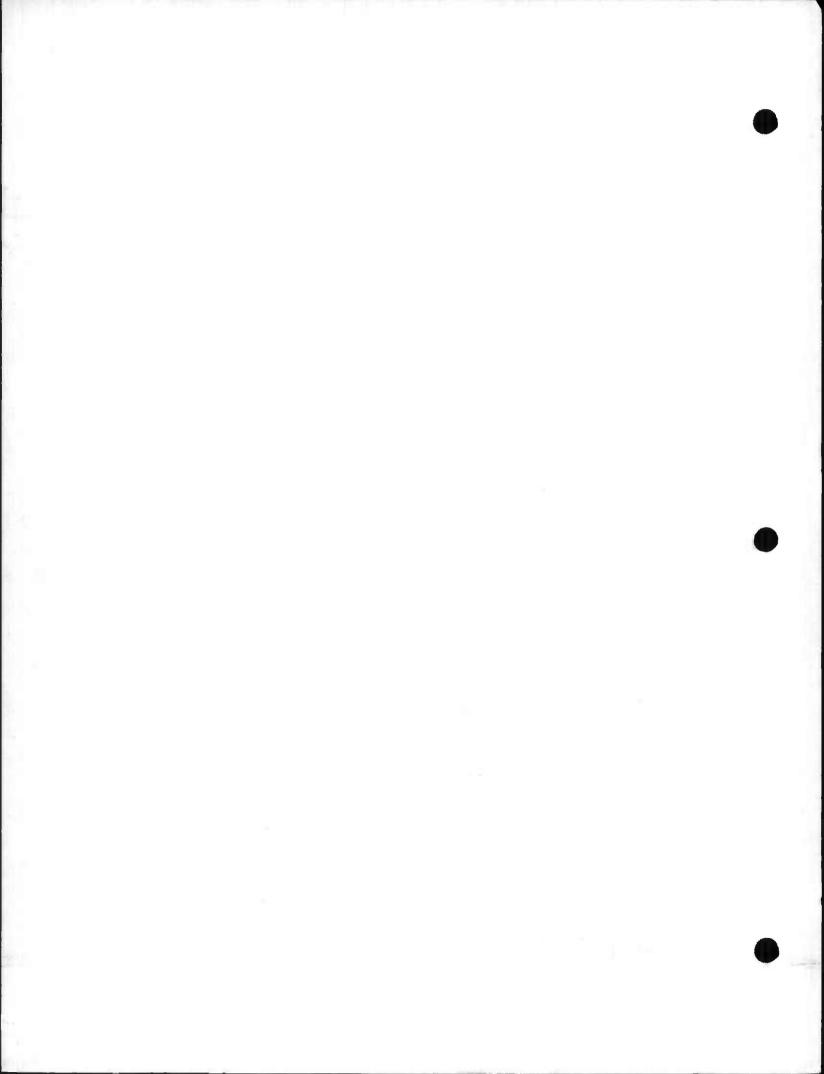
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directio, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

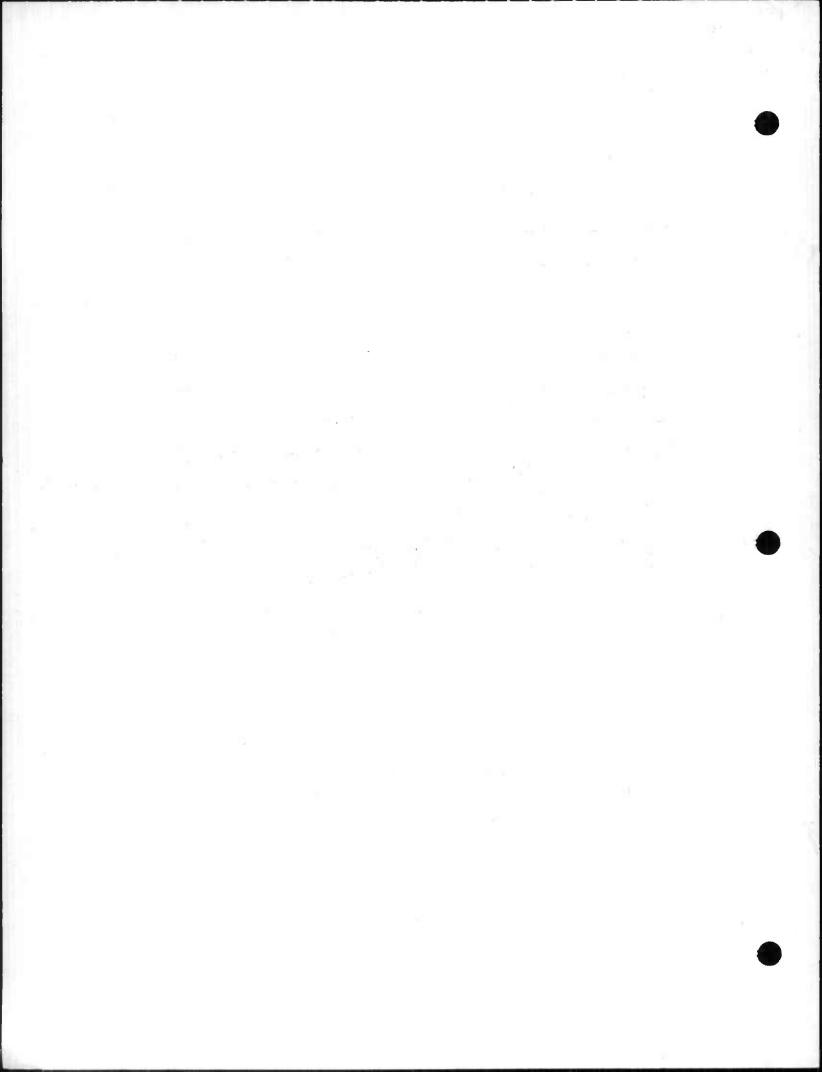
	REGISTRAR	CERTIF	ICATE	F DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)  Marvel Leone	a Rox	9		2. DATE OF DEATH DON'TH DI	9 199%	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. SEX 479-20-1455 1 \( \text{I} \) M 2 \( \text{X} \)F	6. AGE (In yrs. lest birthday) 71 YRS.	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)			
_	9e. FACILITY NAME (If not institution, give street and number)	7 1 1110		N OR LOCATION OF DE	OCT.6,192	9c. COUNTY	ENARDEN, IA.  OF DEATH MORE CITY			
DIRECTOR	MERCY HOSPITAL		BALTI	TORE		DALII	MORE CITI			
l m	10e. STATE 10b. COUNTY		Y, TOWN OR LO				10d. INSIDE CITY			
	MARYLAND BALTIMORE CI	TY BA	LTIMOR				LIMITS?  1X YES 2 NO			
FUNERAL	2116 PARKSLEY AVENUE			21230		U.S.	OF WHAT COUNTRY? A.			
B	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT FORCES? 1  IF YES, GIVE W	FEVER IN U.S. ARMED YES 2 X NO AR OR DATES	If yes	DECENDENT OF HISPAN specify Cuben, Mexican (ES 2 NO Specify		- 10	14. RACE — American Indien, Black, White, etc. Specify: WHITE			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT'S	USUAL OCCUP	ATION most of working	16b. KIND OF BU	SINESS/INDUST	TRY			
COMPLETED	Elementary/Secondery (0-12)  4 YRS PLUS	SCHOOL	work done during se retired.) TEACHE		BALTI	MORE C	ITY			
	17. FATHER'S NAME (First, Middle, Last) ROBERT WRIGHT			18. MOTHER'S NAI HELEN J	ME (First, Middle, Maiden OHNSON	Sumeme)				
TO BE	190. INFORMANT'S NAME (Type/Print) MR. THOMAS O. ROSE	196. MAILING 2.1.1.6	PARKSL	et and Number or Rural F EY AVENUE	Houte Number, City or Tow	n, State, Zip Coo	21230			
Ċ	20a_METHOD OF DISPOSITION 20b_PLACE AND DATE OF DISPOSITION (Name of OATE 20c_LOCATION — City of Town, State									
176	4 Donation 5 Other (Specify)	CEDAR HI				TIMORE				
	21. SIGNATURE OF FUNERAL BERVICE LICENSEE	lannor	HUBB		L HOME, IN VENUE-Balt		Md 21229			
	23. PART Enter the diseases, or complications the	ceused the daeth. Do	not enter the	mode of dying, auch	h as cardlec or reap	retory arrest.	Approximate			
	ahock, or heart failure. List only one cau IMMEDIATE CAUSE (Final	sa on aach lina.					Intarval Batween Onset and Daath			
	resulting in death)	20515 OILAS A CONSEQUENCE O	in.				20 hours			
NO	Sequentially list conditions,  for any, taeding to immediate  Sepsis  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
CATIC	of any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  Due to (or as a consequence op):  1									
CERTIFICATION	that initiated events resulting in death) LAST	OR AS A CONSEQUENCE O	F):							
	PART II. Other aignificant conditions contributing to	death but not resulting	in the underl	/ing cause givan in	Part I. 24e. WAS AN	AUTOPSY	24b. WERF AUTOPSY FINDINGS			
EDICAL	toxic megacolon,					RMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MED	dew bitus vicers	•				94.10	OF DEATH?			
Ä	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL	TO CAUSE OF								
SICIAN	EXAMINER? HOSPITAL:	ER/Outpatient 3 🗆 DOA	OTHER:	PLACE OF DEATH (Che						
РНҮ	27. MANNER OF DEATH 28e. DATE OF	INJURY 28b. TIM		INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED			
B	1 Netural 5 Pending 2 Accident Investigation	INJURY — At home, farm,	M. 1	YES 2 NO	281. LOCATION (Street	and Number or 6	Jural Boute Mumbar			
ETED	S Could not be determined building,	etc. (Specify)			City or Town, State)	and redinder of r	to an Proble Northber,			
COMPL	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of examiner: On the best of ex						suse(s) and menner se stated.			
E C	296. SIGNATURE AND TITLE OF DERTIFIER			29c. LICENSE NUM			GNED (Month_ Day, Year)			
TO BE	Mulley			1 608	5174	► VIL	ne 19, 1995			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	E OF OEATH (ITEM 27) (Type	a, Print)	-						
	31. DATE FILEO (Month, Day, Year) 32. REGISTRA	R'S SIGNATURE								
	JUN 2 3 1995 Juli Stavelson	- NANGALA /								



						No		35	1891	5	
	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)		0		1	2. DATE OF DEATH DAY YEAR			3. TIME OF DEAT	Н	
	tawin		KOS	enblad	<b>†</b>	June	19, 10	395	3:02	AM	
	173-10-7758	173-10-7758 1 M 2 F 84 YRS. MONTHS DAYS HOURS MHN. Dec. 30, 1910 Pe								reign	
	9e. FACILITY NAME (If not inetitution, give street	et and number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH		TY OF DE			
DIRECTOR	Suburban Hospital			Bethes	da		Mon	tgom	ery		
l D	10e. STATE 10b. COUNTY	CEDENT									
E	Maryland Montgo	Montgomery Rockville									
A A	10e. STREET AND NUMBER		-		r. ZIP CODE		10g. CITIZ		HAT COUNTRY?		
ᇤ	6013 Neilwood Driv	ve			20852		U	SA			
FUNERAL		12. WAS DECEDENT EVER FORCES? 1 X YES		13. WAS DE	CENDENT OF HISPAN	HC ORIGIN? (Specify Yen, Puerto Rican, atc.)	e or No-	14. RACE	- American India White, etc.	n,	
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			3 2XXNO Specify		İ	Specify			
03	15. DECEDENT'S EDUCAT	TION	16a, DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	CINECO/IND	HOTEV	wiitte		
Ē	(Specify only highest grade co	College (1-4 or 5+)		work done during m		TOOL KIND OF BO	311123071110	OSTAT			
를	12 Yrs		Grocer	& Pizza	Restaura	nt Merc	hant				
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)				
BE	Thomas Rosenblatt				Saral	n Marcus					
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox					
	Thomas M. Rosenblatt  200. METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Removel from State 4 Donation 8 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  6013 Neilwood Drive, Rockville, Maryland 2  20b. PLACE AND DATE OF DISPOSITION (Name of Camelogy, or other plage)  20b. PLACE AND DATE OF DISPOSITION (Name of Camelogy, or other plage)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY										
									yland		
	STEIN HEBREW MEMORIAL FUNERAL HOME, INC.										
	22 PART I Enter the discourse or on	*	-	U	ARROLL ST	C, NW, WAS	HINGT	ON, I			
	23. PART i. Enter the diseases, or cor ahock, or heart fellure. Lis	at only one ceuse on	each line.	not anter the me	ode of dying, suc	h aa cardiac or reap	iratory arre	eat,	Approxima interval Be	tween	
	IMMEDIATE CAUSE (Final disease or condition PAMPISE HEART BY COLE AND ACYCLASIS										
	DUE TO (OR AS A CONSEQUENCE OF):										
z	disease or condition resulting in death)  a. COMPLETE HEART BLOCK AND ASYSTOLE 5 MIN  DUE TO (OR AS A CONSEQUENCE OF):  CORDINARY ARTERY DISEASE  10 USARS										
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):									
2	CAUSE (Disease or Injury										
붙	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE O	F):							
	d								-		
P.	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PROPRIED?  PERFORMED?  ANALABLE PRIOR TO										
1 2		ENAC DI					NO		MAILABLE PRIOR T COMPLETION OF CA OF DEATH?		
MEDICAL		NDENT.	-	5			()	1	YES 2 1/N	0	
ÿ	DID TOBACCO USE CONTRIE	BUTE TO CAUSE		S NO	UNCERTAIN	1 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE DF DEA	TH (Check only one) OTHER:							
1YS	1 TYES 2 NO 1	28e. DATE DF INJURY		4 🗆 Nursing Hon	ne 5 🗆 Residence						
	1 Natural 5 Pending	(Month, Day, Year)		JURY WO	JURY AT ORK? YES 2 ND	28d. DESCRIBE HOW	NJURY OCC	URED			
ВУ	2 Accident Investigation 3 Suicide 8 Could and be	28e. PLACE OF INJUS	RY — At home, term,			281. LOCATION (Street	and Number	or Bural Bo	uto Mumbar		
ETED	4 Homicide 8 Could not be determined	building, atc. (Sp	ecify)			City or Town, State	and reamber	or norer no	oto Namber,		
<u>"</u>	29a. CERTIFIER 1 X CERTIFYING PHYSICIA	AN: To the best of my kno	wledge death occurs	ad at the time date	and alone and dis	4.0.	sus-entropy				
COMPL		On the basic of examinati							end manner es et	nted.	
E CC	29 SIGNATURE AND TITLE OF CERTIFIER	~0			29c. LICENSE NUN				Month, Day, Year)		
8	Kolu Jauenn	m ( )}			D-205	35	D (2	/19	19		
유	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	PEATH (ITEM 27) (Type	, Print)	0 700		7	1.61	20		
	KOGERSTEVENSO	W, VR M.	6410	POLKLE	OGE DA	#200 B	EVHE	SOF	M20	814	
	31. DATE FILED (Month, Day, Year)	32. FEGISTRAR'S SIG	NATURE					-			
	JUN 2 3 1995 Julia Studier Randell										

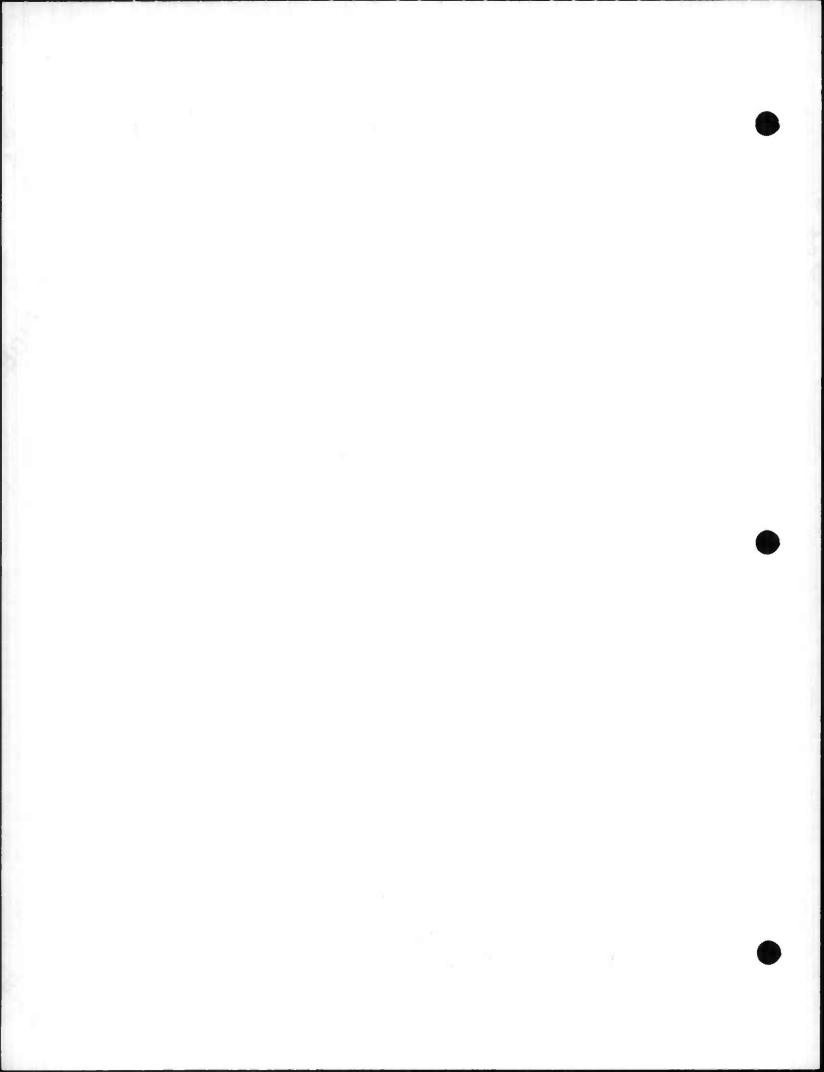
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	HEGISTHAR		CERTIF	ICALE	OF DEATH	REG. NO	D			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	3. TIME OF DEATH		
	KRISTA	LYNN	RUGO	GLES			9	95 5:00		
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 Y		7. DATE OF BIRTH		BIRTHPLACE (State or Fore Country)		
	211-60-7254	1 M 2 X F	16 YRS.	MONTHS D	AYS HOURS MIN.	June 28,	1978	Pennsylvani		
	9a. FACILITY NAME (If not institution, give s	treet and number)		96. CITY, TO	OWN OR LOCATION OF D	EATH	9c. COUNT	TY OF DEATH		
СТОВ	FOOKS & CIRCLE	ROAD		WH:	ILEYVILLE	2	WORG	CESTER		
5	RESIDENCE OF DECEDENT									
DIRE	10a. STATE 10b. COUNTY			Y, TOWN OR L				10d. INSIDE CITY		
FUNERAL DI		lair	Duncan	sville			1 TES 2 N			
	10a. STREET AND NUMBER			101. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?			
Ħ	69 Muleshoe Est	tates			16635			U.S.A.		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	R IN U.S. TRIMED	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Y	a or No- 1	4. RACE — American Indian		
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR		1 🗆	s, specify Cuban, Maxic YES 2 Z NO Speci	nn, Puerto Rican, etc.) fy:	- 1	Black, White, etc. Specify:		
			-				White			
Ē	19. DECEDENT'S EDU (Specify only highest grade		16e. DECEDENT'S	work done during	PATION ng most of working	16b. KIND OF BI	JSINESS/INDU	STRY		
BE COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	IM. Do NOT u	IN. Do NOT use retired.)						
	11 yrs.		Stude	ent		Edu	cation	1		
	17. FATHER'S NAME (First, Middle, Lext)				18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)			
	A STATE OF THE PARTY OF THE PAR	gles			Car	ol Gi	11			
	19s. INFORMANT'S NAME (7/pe/Frot)		196. MAILING	ADDRESS (S	treet and Number or Rural	Route Number, City or To	wn, State, Zip C	Code)		
TO	Carol Ruggles		Sar	ne as	#10					
	20s. METHOD OF DISPOSITION 1 XX Ourtal 2 □ Cremetion 3 □ Rem	2	10b. PLACE AND DATE	OF DISPOSITIO	ON (Name of	DATE 20c. L	OCATION CI	ty or Town, Stata		
	4 Donation 5 Other (Specify)	ownt from State	Alto Rest	to Reste Park Cemetery 6/24/95 Allechent TWP, Pa						
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE O	F):	blunt					
3	The state of the s	- Contributing to death	out not readiting	in the under	nying cause given in	PERFO	RMED?	24b. WERE AUTOPSY FIN AVAILABLE PRIOR TO		
EDICAL						1 YES	2 - NO	OF DEATH?		
×	DID TOPACCO LICE CONTE	DIDLITE TO CALLES	OF DEATH A	C 🗆	— III.			TYES 2 N		
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
SICI	EXAMINER?	HOSPITAL: OTHER								
ΙΥS	1 XYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Ou		-		The (Specify)				
РНУ	1 Netural 5 Pending	28a. DATE OF INJURY	219-95 Fan 19	USY O	WORK?	28d. DESCRIBE HOW	INJURY OCCU	RED		
BY	2 Accident investigation	MINNON	unk	Nun.	YES 2 NO	Subject	Stra	ngled		
	3 Suicide 8 Could not be 4 Homicide detarmined	building, etc. (Sp		street, factory,	office	281. LOCATION (Street City or Town, State		Rumi Raula Number		
E		Found in				FOOVS +	Circi	e Rd		
됩		CIAN: To the best of my kno								
COMPL		R: On the basis of examinat								
	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NU			SIGNED (Month, Day, Year)		
BE		Plan			O.C.M.		JU	JNE 20,199		
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF I	DEATH (ITEM 27) (Time	Print)			1			
	David R F	ruler					100-	, , , , , , , ,		
	1.70		III Pe	enn S	treet, Ba	iltimore,	Mary	land 2120		
	JUN 2 3 1995	32. REGISTRAR'S CO	dell							
- 1	L CCCI V VIIOC 12									



		REGISTRAR		CERTIF	ICATE	OF DEATH	REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)	FRANK RINGL	K	NE	LEY	2. DATE OF SEATURE MOUNT OF 2.2	6/22 199	5 3. TIME OF DEATH	M	
T.		4. SOCIAL SECURITY NUMBER 2/7-20-8059	5. SEX 6. AGE	(In yrs. leaf birthdey) 7 YRS.	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Virginia	מק	
3 should		9a. FACILITY NAME (If not institution, give a	treet and number)		9b. CITY, TO	WN OR LOCATION OF DE		9c. COUNTY			
2,3	CTOR	6000 000 0									
Pages	REC	10s. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR L	DCATION			10d. INSIDE CITY	_	
permit. Pa		Maryland Ca:	rroll County			Sykesvi	11e		1 YES 2 X NO	,	
ışı	FUNERAL	6825 White Rock	Road			10f. ZIP CODE 21784			OF WHAT COUNTRY?		
5-0020 nding physician. ss the bunal-transit	B∀	11. MARITAL STATUS 1 Never Merried 2 Married 3 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYPES IF YES, GIVE WAR OR D	2X NO	If ye	DECENDENT OF HISPAN s, specify Cuben, Maxica YES 2 NO Specify	n, Puarto Rican, etc.)	or No 14	RACE — American Indian, Black, White, etc. Specify: White		
attending se as the	0	15. DECEDENT'S EDU		16a. DECEDENT'S	USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDUS	TRY		
12 mg		(Specify only highest grade Elementary/Secondary (0-12) 12	Coffege (1-4 or 5+)	(Give kind of life, Do NOT u	work done durir se retired.) Plumb	g most of working		umbing			
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			1 L GIIID				>		
3 & 6 A	ш	Joseph C.	Ringley				ME (First, Middle, Maiden Ce Collins		LVV		
4 5 2 €	10 B	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	eet and Number or Rural I	Route Number, City or Town	n, State, Zip Co	rde)		
2 2 2	F	Mrs. Shirley P.	Ringley	682	5 Whit	e Rock Roa	d Sykesvil	le, MI	21784		
may be		20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Reme	oval from State	. PLACE AND DATE	OF DISPOSITIO	N (Name of	DATE 20c. LO		y or Town, State		
E de G	1 1	4 Donation 5 Other (Specify)		Lake Vie				kesvil	lle, MD		
ALLIN death. Pag tuneral di tuneral di examiner	1 1	21. SIGNATURE OF FUNERAL SERVICE LIC		,		GHT FUNERA		O Pos	. 105)		
			1. Haigh		Svk	esville. M	D 21784 (4	10)-79	95-1400		
filled in by on, or remo		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in deeth)  Approximate interval Between Onset and Daeth  Onset and Daeth									
executed and com o burial, matic ex	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSCOURNCE OF):  DUE TO (OR AS A CONSCOURNCE OF):  DUE TO (OR AS A CONSCOURNCE OF):									
th certifican ending phys I Hygiene p	ERTIFI	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):									
the death the atte d Mental injury, 0		PART II. Other aignificent condition	s contributing to death b	out not resulting	in the under	lying cause given in	Part I. 24s. WAS AN	ALITOREY	24b. WERE AUTOPSY FINDI	4400	
and an	EDICAL	5 ssential	Hype		Slow	ying cades given in	PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION DF CAUS		
S e e e	MED						1 YES 2	(INO	OF DEATH?		
3 5 5 8	AN:	DID TOBACCO USE CONTE	RIBUTE TO CAUSE O	F DEATH YE	S NO	☐ UNCERTAIN	1 🗆				
N: The law Norte has State Dep	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:						
SICIAN: The Certificate the State in the State i, or item	нүз	1 YES 2 NO	28a, DATE OF INJURY	petient 3 DOA 28b. TIM		Home 5 Residence					
F # # 5	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1	WORK?	28d. DESCRIBE HOW II	NJURY OCCUR	ED		
TTENDI TTOR: A after da	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	/ — At home, farm, :	street, factory,	office	281. LOCATION (Street a City or Town, State)	nd Number or i	Rural Route Number,		
te de la la la la la la la la la la la la la	PLE	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death occurre	ed at the time,	date and place, and dua	to the cause(s) and man	mer ea atated.			
HOSPITAL FUNERAL WITHIN 72 I	COMPL	One) 2 MEDICAL EXAMINE	On the basis of examination						sure(a) and manner sa state	d.	
TO THE HOSPI TO THE FUNEF De filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WHO	a_ Affer	dung	Pays1	29c. LICENSE NUN	19402	29d. DATE SI	GNED (Month, Day, Year)		
		S. DEVI	AUJLA	540	000	D COUR	10 ALLS	Tou	M 2113	3	
		JUN 2 3 1995	32. REGISTRAR'S SIGN	ardall							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



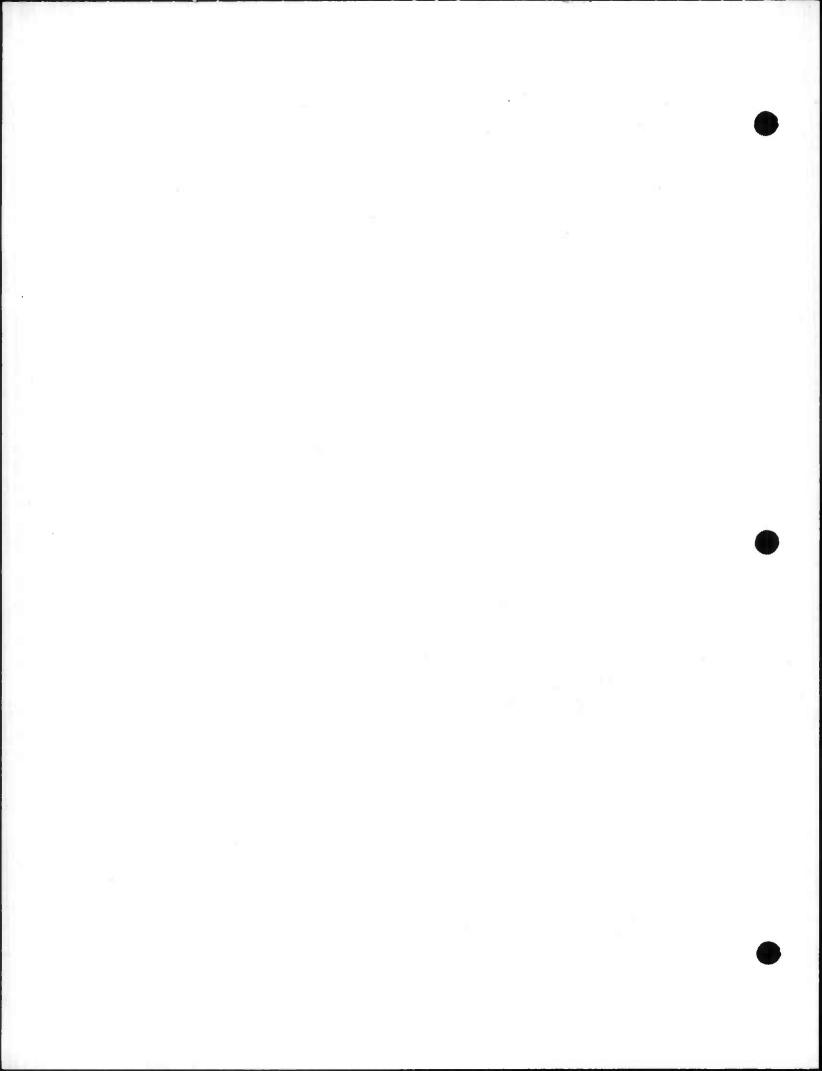
E, MARYLAND 21215-0020	attending physician.
ND 21	hospital or
YLA	by the
MAR	retained
JRE,	may be
TIMORE	Page 6
IALI	death.
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	things in

DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH  3. TIME OF DEATH														
	Lillian Catherine Roubal										June 19, 1995 YEAR 3:00 P. M				3.00 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. I		(In yrs. lest t	last birthday) IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH			8. BIRTHPLACE (State or Foreign			
	212-30-1112	1□M2 StF 74		ı	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, D March		021	Count		
	90. FACILITY NAME (If not instit	tution, give str	eet and number)				9b. CITY	TOWN	OR LOCATI	ION OF DE		0, 1		INTY OF D	_
œ	Manor Care To			or Ho	mo						5411				
DIRECTOR	RESIDENCE OF DECE	DENT	NULSII.	ig no	me		TOW	son					Ba1	time	ore County
Ĭ,	10e. STATE 10	0b. COUNTY				10c. CITY	TOWN O	R LOCA	TION						10d. INSIDE CITY
<u></u>	Maryland	N/A				Bal	timo	re (	City						LIMITS?
¥	10e. STREET AND NUMBER							_	1. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
띪	2719 Chesley	Avenu	е						21234	1			U.S	; Z	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARMI	ED	13. 1	WAS DEC	ENDENT (	OF HISPAN	IIC ORIGIN? (S	pecify Yee		14. RAC	E — American Indian,
	1 Never Married 2 Me		FORCES? 1 IF YES, GIVE V						ecity Cube		n, Puerto Rica	n, atc.)			k, White, etc.
B	3 Widowed 4 Divorce	••												Whi	te
	15. DECED (Specify only hi	ENT'S EDUC			16a. DECE	DENT'S L	JSUAL OC	CCUPATI	ON ost of world	na	16b. KII	ID OF BUS	INESS/IN	OUSTRY	
9	Elementary/Secondary (0-12	2)	College (1-4 or 5	+)	life. D	o NOT use	retired.)								
M P	7th Grade				Sale	es					Dep	partn	ent	Stor	e
COMPLETED	17. FATHER'S NAME (First, Midd	fle, Last)							18. MOT	HER'S NA	ME (First, Midd	le, Maiden	Sumame)		
BE	Frank			Huda.	k				Anna	l			Eck]	Le	
0	19e. INFORMANT'S NAME (Type				19b.	MAILING .	ADDRESS	(Street	and Numbe	r or Rural F	Route Number,	City or Town	, State, Zij	p Code)	
	Kathleen Lill:			ein	27	719 (	hes.	ley	Aven	ue,	Baltir	ore,	Mar	vlan	d 21234
	20a, METHOD OF DISPOSITION 1 Buriel 2 Cremation	N 3 □ Remo	val from State		PLACEAN	DDATEO	FDISPOS	ITION (N	ame of		OATE	20c. LO	CATION -	City or To	own, State
	4 Donetion 5 Other (Sp	pecify)		Pa	arkwc	bod (	ene	tery	7	6/	22/95	Bal	timo	re,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  John C. Miller, Inc.														
	►Katil.	. )	mm		//	/	NOI	nn (	. Mi	Titer	, inc.	14.24.		36	-1- 7 07 006
	23. PART I. Enter the dise	asea, or co	empilcations the	t caused	the deat	h. Do no	nt enter	the mo	de of dy	L RO	au, Ba	TETH	ore,	Mar	yland 21206
	anock, or neer	rt renure. L	let only one ceu	ise on a	ach line.				,			or roup.	atory a.		Interval Between
	IMMEDIATE CAUSE (Finel disease or condition					2 Ctroke						Onset and Death			
	resulting in death)	8.	DUE TO	COBIAS A	CONSEQUENCE OF):						19				
.			<	1000	P1-0	citoc or j	Do	260	-0.00						1446
CERTIFICATION	Sequentially list condition		DUE TO	(OR AS A	CONSEGU	ENCE OF	1/	1	77	260	> ,	*			
Ă	if any, leading to immedia cause. Enter UNDERLYING	G	Ad	VA	need	1	1 Hh	eli	Sil	and to	1. 1.	~ PM	~		1 5 4K
Ĕ	CAUSE (Disease or Injury that initiated events	1 "	DUE TO	OR AS A	ponsequi	ENCE OF	1			Jan U	C UV	300			+ - /
2	resulting in death) LAST	100		Del	ha o	lan	tw	~							2 w/cs
- 11					7"	V-1.									-
DICAL	PART II. Other aignificant	conditions	contributing to	death bu	ut ngt ree	of resulting in the undarlying cause given in			given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?			24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă											1	YES 2	NO		COMPLETION OF CAUSE OF OEATH?
Σ													7		1 - YES 2 NO
z I	DID TOBACCO USE	CONTR	IBUTE TO CA	USE O	F DEATH	H YES	1 🗆 S	10 E	JUNC	ERTAIN	1 X				/ /
5	25. WAS CASE REFERRED TO M EXAMINER?		HOSPITAL	- :	28. PLACE		-	, ,							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  25. WAS CASE REFERRED TO MEDICAL  EXAMINERY  1   YES   2   NO   28. PLACE OF DEATH (Check only one)  EXAMINERY  1   OF DEATH   28. PLACE OF DEATH (Check only one)  EXAMINERY  1   OF DEATH   28. DATE OF INJURY  (Month, Day, Ver)  28b. TIME OF   28c. INJURY AT WORK?  WORK?															
Ξ	27. MANNEY OF DEATH		28e. DATE OF (Month, D			28b. TIME INJU	OF IRY	28c. INJ WC	URY AT		28d. DESCRI	BE HOW IN	JURY OC	CURED	
B	Natural 5 Per	nding estigation					M		YES 2	NO					
- 10		uld not be	28e. PLACE O building,	otc. (Speci	— At home	, ferm, st	reet, lacto	ory, offic	•		281. LOCATIO	N (Street e	nd Number	or Rurel I	Route Number,
4 Homicide determined															
								) and man							
<u> </u>	(Check only 1 CERTIFY	YING PHYSICI	AN: To the best of	my knowle	ledge, death	(Check only one)  2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner									
OMPI	(Check only														s) end manner as atated.
- 11	(Check only	L EXAMINER							leath occur	red at the	time, date end		due to It	ne ceuse(s	
# H	(Check only one) 2 MEDICA	L EXAMINER					, in my o	pinion, d	leath occur		time, date end		due to It	ne ceuse(s	Month, Day, Year)
# H	(Check only one) 2 MEDICA	L EXAMINER	On the besis of e	xamination	n end/or inv	stigation	51°C	pinion, d	29c, LICI	ense num	time, date and		due to It	ne ceuse(s	
TO BE COMPI	(Check only 2 MEDICAL 29b. SIGNATURE AND TITLE OF	L EXAMINER	On the besis of e	xamination	n end/or inv	stigation	51°C	pinion, d	29c, LICI	ense num	time, date and		due to It	ne ceuse(s	Month, Day, Year)
# H	(Check only 2 MEDICAL 29b. SIGNATURE AND TITLE OF	ERSON WHO	On the besis of e	xamination	n end/or inv	stigation	51°C	pinion, d	29c, LICI	ense num	time, date and		due to It	ne ceuse(s	Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

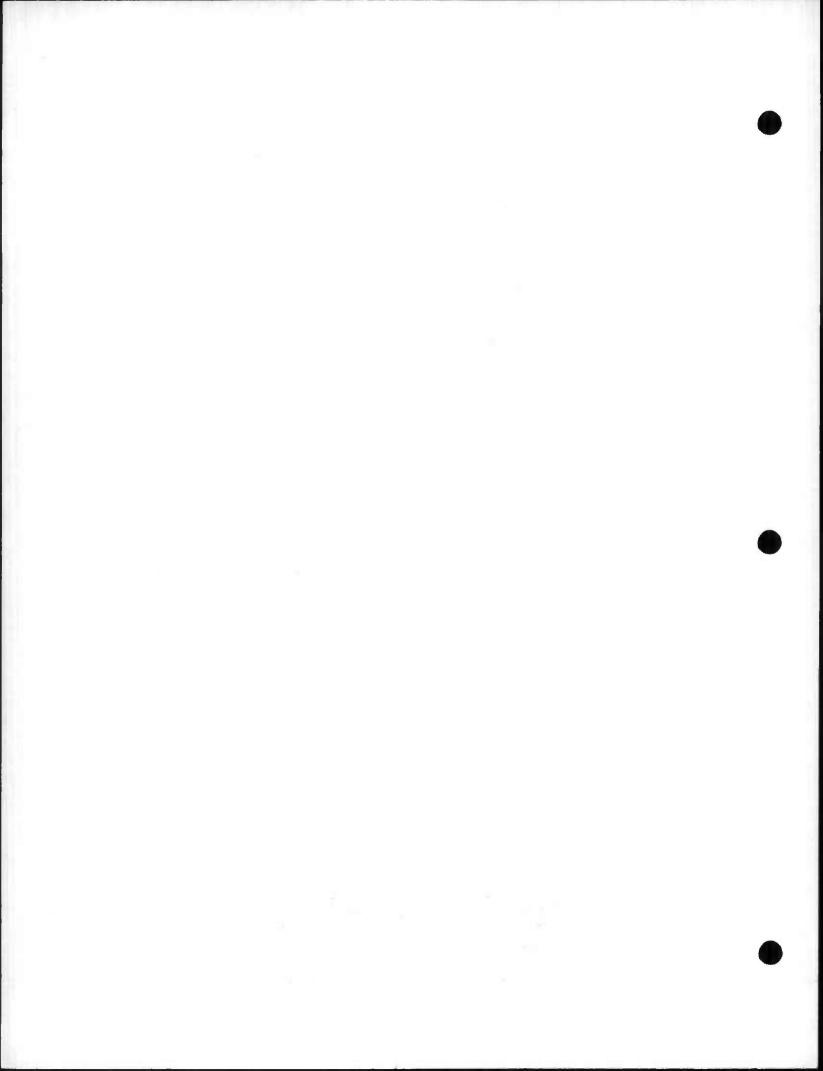
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Menial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CER	HIFICA	IE OF	DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	AV	VEAD 3	TIME OF DEATH	
	Carl Willia	m Ruch					June 21,	199	5	10 Pm	
	4. SOCIAL SECURITY NUMBER	5. SEX 8.	AGE (In yrs. last birt		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPL	ACE (State or Foreign	
	213-12-8885	1 🔯 M 2 🗆 F	73	RS. MONTH	B DAYS	HOURS - MIN.	July 14, 19	21	Mary	land	
	9e. FACILITY NAME (If not institution, give st	reet and number)		9b. C	ITY, TOWN	OR LOCATION OF D			NTY OF DEA		
DIRECTOR	Carroll County Ge	eneral Hos	pital	-4	Wes	tminster		C	arrol	1 County	
5	RESIDENCE OF DECEDENT										
2				c. CITY, TOW					10	Dd. INSIDE CITY	
		coll Count	У		5	ykesvill	.е		1	YES 2 NO	
3AL	10e. STREET AND NUMBER				10	f. ZIP CODE		10g. CITI	ZEN OF WH	AT COUNTRY?	
FUNERAL	6341 Oklahoma Ro					21784		1	U.S.A		
5	11. MARITAL STATUS	12. WAS DECEDENT ET					NIC ORIGIN? (Specify Yes	or No-	14. RACE -	- American Indian, White, etc.	
ВУ									Specify:	White	
			WWI							WILLE	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give ki	ENT'S USUAL and of work do. NOT use retire	ne durina m	ON ost of working	16b. KIND OF BU	SINESS/IND	USTRY		
2	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	ma. Do i	Custo			Roand	of	Educa	tion	
Š.	17. FATHER'S NAME (First, Middle, Last)	9		custo	ulan				Educa	CIOII	
	William Hern	nan Ruch					ME (First, Middle, Meiden Lmie Ella S		OV		
B	19a, INFORMANT'S NAME (Type/Print)	1011 110011									
2	Mrs. Ellen V. Ru	ıoh					Route Number, City or Tow Sykesville			/.	
	20a. METHOD OF DISPOSITION	ICII									
	1 X Buriel 2 Cremetion 3 Remo	rval from State	20b. PLACE AND I cemetery, cremato						City or Town		
	4 Donetton 5 Other (Specify) Lake View Mem. Park 6/26/95 Sykesville, MD  21. SIGNATURE OF FUNERAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY										
	A		/	Ι,			CAL HOME (E	· n	Boy 1	95)	
_ !!	buan &.	Haigh					MD 21784				
	23. PART I. Enter the diseases, or c	omplications that co	used the desth.	Do not an	er the mo	de of dying, suc	h ss cardlec or respi	ratory arm	est,	Approximata	
	ahock, or heart failure. [ IMMEDIATE CAUSE (Final	.ist only one cause	Dn each lina.							Interval Between Onset and Daeth	
	disease or condition resulting in death) . REPRACTORY SETZURES										
ĺ	DUE TO (OR AS A CONSEQUENCE OF):										
z	METASTATIC SMALL CELL WING CA										
	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	Cause. Enter UNDERLYING CAUSE (Disease or injury										
E	that initiated events	DUE TO (OR	AS A CONSEQUEN	ICE OF):							
CERTIFICATION	resulting in dasth) LAST	ı									
0	PART II. Other significant conditions	contributing to de	eth but not resul	ting in the	underlyln	a cause alves la	Part I. 24s, WAS AN	ALITODON		ERE AUTOPSY FINDINGS	
EDICAL		,		ting in the	diadelly	g cause givan in	PERFOR		AN	AILABLE PRIOR TO	
							1 🗌 YES 2	NO NO		OMPLETION OF CAUSE F DEATH?	
Σ	DID TOR ACCO LICE CONTR	IDILITE TO CALL	- 05						1	YES NO	
N N	DID TOBACCO USE CONTR	IBUTE TO CAUS				UNCERTAII	101				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	OTH	-						
YS	1 TYES 2 NO	1	/Outpatient 3 🗆 0			e 5 🗆 Residenca	8 Other (Specify)				
표	27. MANNER OF DEATH Natural 5 Pending	(Month, Day, Y		b. TIME OF	28c. IN.	URY AT	28d. DESCRIBE HOW II	NJURY OCC	URED		
B	2 Accident Investigation			М		YES 2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF IN building, atc.	JURY — At home, f (Specify)	erm, streef, f	actory, offic	•	28f. LOCATION (Street a City or Town, State)	and Number	or Rural Rout	e Number,	
Ē.											
COMPLETED	(Check only	IAN: To the best of my	knowledge, death o	ccurred at th	e time, data	and place, and due	to the ceuse(a) and man	ner as state	ed.		
O O	2 MEDICAL EXAMINER	: On the basis of exami	nation and/or invest	tigation, in m	y opinion, d	eath occured at the	time, data and placa, an	d due to the	e cause(e) ar	nd manner as stated.	
	296 SIGNATURE AND TITLE OF AUTHER		110			29c. LICENSE NUN	MBER	29d. DATE	SIGNED /M	onth, Day, Year)	
BE	Pull our	W	(W)			D3539	18	161	22.15		
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE C	F DEATH (ITEM 27)	(Type, Print)		4		U	[(	3	
	HAVIO KRUP	en Ge	34 A PO	OCE	RD	WESTA	HARLEN	MD	21	ハナ	
Ì	JUN 2 3 1995	PALIA OF THE	SIGNATURE LOCKARDALL							F	



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

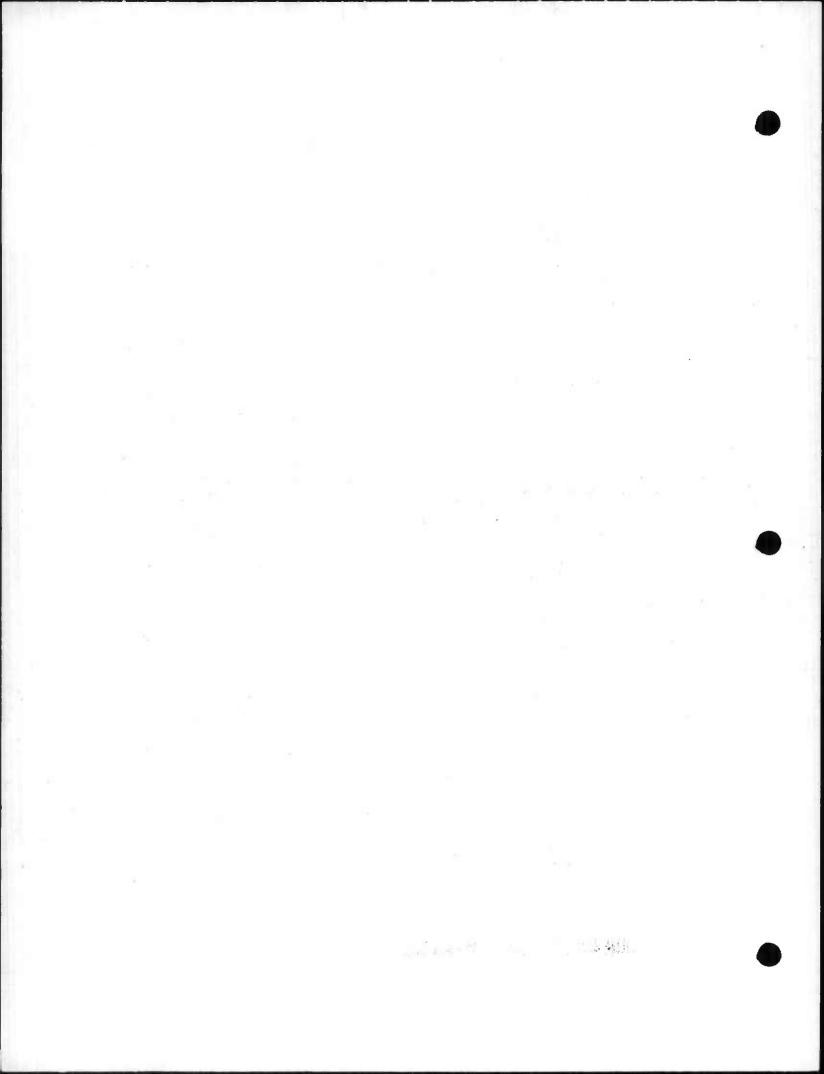
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be districtly brunca rather death with the State Death of Health and Mental Hunison price to hard completely filled.

		FOR	CTATE OF I	AADVI AND /	DEDAG	THENT OF	OPAIRU AND	Mental Inc.	95		8920
		1 - STATE REGISTRAR	SIAIE UF I	MAKTLANU / CI	DEPAR	ICATE O	HEALIH AND F DEATH	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Lest)					DEATH	2. DATE OF DEATH	0	3.	TIME OF DEATH
		DONALD		SA	NDEF	SON		JUNE 1	DAY 100	YEAR	11/1/ My M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1,100		CE (State or Foreign
		213-72-5252	1√2M2□F	36 yrs	YRS.	MONTHS DAY	HOURS MIN.	Jun 7, 19	159	George	
		9e. FACILITY NAME (If not institution, give s	treet and number)	00 /20	_	9b. CITY, TOW	N OR LOCATION OF E			TY OF DEAT	
	NC.										
	5	RESIDENCE OF DECEDENT							1 50.	MERSI	5.1
	DIRECTOR	Maryland Ha			y, town or Loc Bel-Air					I. INSIDE CITY LIMITS?	
	AL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WH									
	FUNER	21 Powell	Avenue					21014	U.5	5.A	
	S	11. MARITAL STATUS		T EVER IN U.S. AR		13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify )	es or No-	14. RACE	American Indian, hite, etc.
	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced  FORCES? 1 YES 2 N  IF YES, GIVE WAR OR DATES					specify Cuben, Mexic ES 2 NO Spec	en, Puerto Ricen, etc.) Hy:			hite Mite
	9	15. DECEDENT'S EDU	CATION			USUAL OCCUPA		16b. KIND OF B	USINESS/INDI	USTRY	
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	life.	Do NOT us		most of working	Housin			
63	MP	7th		P	aint	er		Balt	imore	City	
at once.	BE CO	17. FATHER'S NAME (First, Middle, Lest) Charles P. Sa	nderson					AME (First, Middle, Meide Perryman	n Sumame)		
notified	TO B	19e. INFORMANT'S NAME (Type/Print)  Joyce Canapp  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1518 Cox Street, Baltimore, Md. 21211									
medical examiner must be		200. METHOD OF DISPOSITION		20b. PLACE	ND DATE (	F DISPOSITION	Name of	DATE 20c, I	OCATION — C	Sty or Town	State
SNE		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	oval from State			Cemeter			ltimo		
no.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	0	-	22. NAME	AND ADDRESS OF F	ACILITY			
Exa		> a alan	Seit	h				, Jr. Fune			
cal	_	23. PART I. Enter the diseases, or o	omplications the	t caused the de	eth Do s	[3818	Roland A	venue, Bal	timore	, Md.	
Det		ahock, or haart fallure.	List only one cau	se on each line		ot antai tiia ii	roue or dying, sur	on as cardiac or rea	piratory arri	HM1,	Approximate interval Batween
the		IMMEDIATE CAUSE (Final disease or condition	00								Onset and Death
rent,		a. O(UM) A  OUE TO (OR AS A CONSEQUENCE OF):									
2	2				., ., ., .	-					
or other traumatic event,	RTIFICATION	Sequantially list conditions, If any, landing to immediate	DUE TO	(OR AS A CONSEC	DUENCE OF	7):					
ta	8	cause. Enter UNDERLYING CAUSE (Disease or Injury									
the	E	that initiated events	DUE TO	(OR AS A CONSEC	UENCE OF	7):					
6	CERI	reaulting in death) LAST	d								
lury.	Τ. Ι	PART II. Other eignificant condition	a contributing to	death but not r	neulting I	n the underly	ing cause given in	Seet I as une s	AL ALEWS DOV		
shows any injur	MEDICAL					The arraging	ang cadas given ii	PERFO	N AUTOPSY PRMED?	AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE
8								1 7 YES	2 NO		DEATH?
sho		DID TOBACCO USE CONTE	DIRLITE TO CA	IICE OE DE A	TU VE	C $\square$ NO	- UNICEDTAL			19	YES 2 NO
123	AN	25. WAS CASE REFERRED TO MEDICAL	GBOTE TO CA			H (Check only on		иП			
Hem	SICIAN	EXAMINER?	HOSPITAL:			OTHER:		-37.	DODY	07.	TA MADA
6	PHY	27. MANNER OF DEATH	26e. DATE OF	INJURY	26b. TIM		NJURY AT	6 XOther (Specify) 28d, OESCRIBE HOW	BODY		IATER
marked,		1 Natural 5 Pending	Found	6-19-95	1998	URY Y	YORK? YES 2 NO	Subject	0	ned	
E	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY At hor	- 11			281. LOCATION (Stree			Number.
28	ETEL	4 Homicide determined		etc. (Specify)	_	Sound		City or Town, Stat	•)		
H Hem	MPLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, der	th occurre	d at the time, de					
K	COM	one) 2 MEDICAL EXAMINE									I manner ee stated.
IMPORTANT	w I	29b. SIGNATURE AND TITLE OF CENTIFIER	MI	1/			29c. LICENSE NU	MBER	29d. DATE	SIGNED (Mor	nth, Day, Year)
ME N	TO B		0	4			OCME	2	<b>▶</b> Jī	UNE 2	0,1995
	F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUS	E OF OEATH (ITEM	27) (Type.	Print)					

Penn Street, Baltimore, Maryland 21201

31. DATE FILEO (Morith, Day, Year)

JUN 2 3 1995



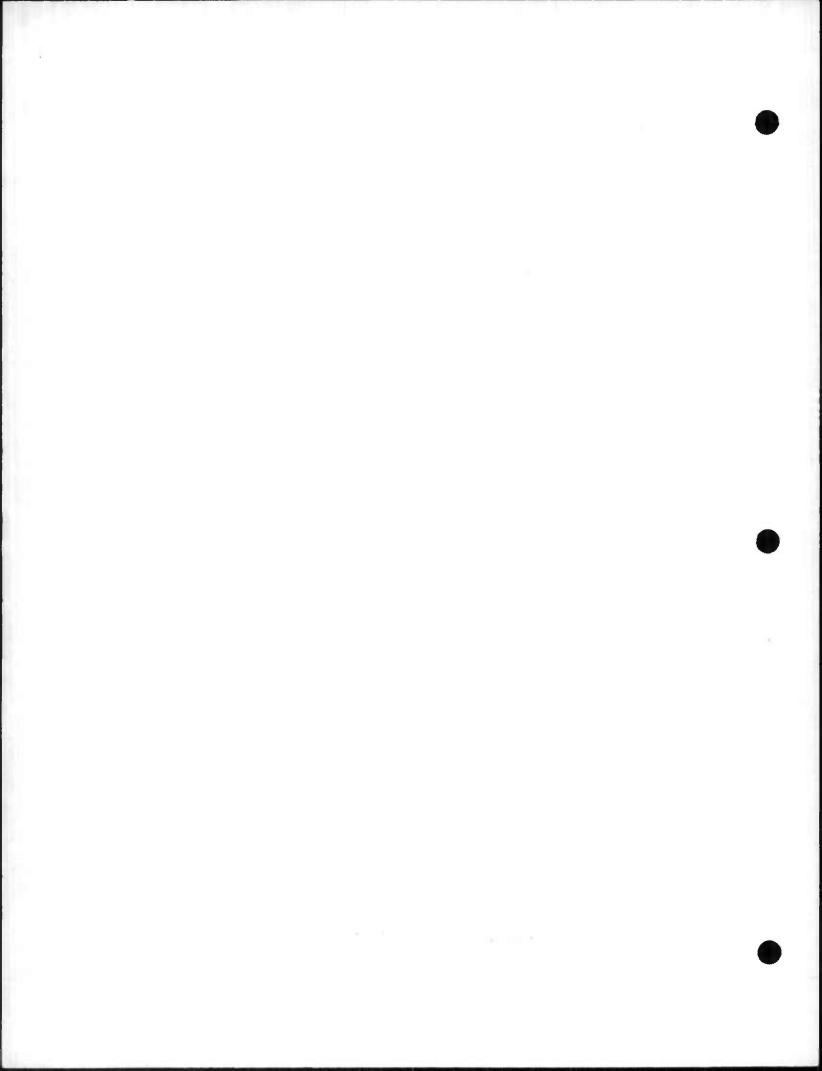
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BALTIMORE, MARYLAND 21215-002	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicians.	CONFIRMING AND ALCOHOLD BY AND AND AND AND AND AND AND AND AND AND
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	4	4
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be without the transit permit of the properties o

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
RAR	CERTIFICATE OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLAND	) / DEPARTMI CERTIFICA	ENT OF H	EALTH AND DEATH		SIENE I. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	тн	3. TIME OF DEATH			
	Milton T. S	impkins				June -	4	YEAR 3: 25 A M			
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs.	MONT	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Y		BIRTHPLACE (State or Foreign Country)			
		XM 2 □ F 42	YRS.			Dec.1		Mary1and			
Œ	9a. FACILITY NAME (If not institution, give street				R LOCATION OF D	EATH	9c. COUNT	TY OF DEATH			
읝	Howard County Ge	eneral		Colum	nbia		Howa	rd			
DIRECTOR	10a. STATE 10b. COUNTY			WN OR LOCAT	ION			10d. INSIDE CITY			
		imore	Arbu	tus				1 TES 2 NO			
RAL	10e. STREET AND NUMBER			101.	ZIP CODE			EN OF WHAT COUNTRY?			
FUNERAL	31 Colony Hill				2122			ed States			
	1 Never Married 2 Married	P. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	NO NO	if yes, spe	cify Cuban, Maxica	NIC ORIGIN? (Speci an, Puerto Rican, el	lfy Yes or No— 1/c.)	4. RACE — American Indian, Black, Whita, atc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 U YES	2 No Specif	y:		Specify: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com-	ON 18a.	DECEDENT'S USUA (Give kind of work di	L OCCUPATIO	N et of working	16b, KIND C	F BUSINESS/INDUS				
<u> </u>	Elementary/Secondary (0-12) C	College (1-4 or 5+)	ille. Do NOT use retin	ed.)	a di di di di di di di di di di di di di						
N N	1 2.  17. FATHER'S NAME (First, Middle, Last)		Disab1	ed			employe	:d			
	Douglas Simpkin	. C.				ME (First, Middle, M		1			
	19a. INFORMANT'S NAME (Type/Print)	18 31.	19b. MAILING ADDR	RESS (Street ar		Simpk:	LNS or Town, State, Zip C	Pariet			
TO BE	Sandra Simpkins					,	butus 2	,			
	20a METHOD OF DISPOSITION 1 DABurial 2 Cremation 3 Removal	20b. PLA	CE AND DATE OF DIS	POSITION (Nat			c. LOCATION — CH				
	4 Donation 8 Other (Specify)	Mea	crematory or other pla	e Men	norial	6/26	Dorsey,	Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY										
	Ambrose Funeral Home Arbutus										
	1328 Sulphur Spring Road 21227  21 PART I. Enter the disesses, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line.										
	IMMEDIATE CAUSE (Fine)							Interval Between Onset and Death			
	disesse or condition resulting in death) a	CEPEBRO.		R ACC	CIDENT			6 DAYS			
		DUE TO (OR AS A CON	SEOUENCE OF):								
O N	Sequentially list conditions, b. —	DUE TO (OR AS A CON	SEOUENCE OF):		-						
\A	if any, leading to immediate cause. Enter UNDERLYING										
E	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A CON									
CERTIFICATION	resulting in death) LAST	END STATE	IE REN	AL P	USF-ASE						
AL C	PART II. Other significent conditions co	ontributing to death but no	ot reaulting in the	undarlying	cause given in	Part i. 24a, W	AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
1 3	DIABETES W	ELLITUS				PE	ERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE			
WEDIC						''		DF DEATH?			
N.	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	EATH YES	NO D	UNCERTAIL	N 🗆					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PI QSPITAL:	LACE OF DEATH (Ch	eck only one) HER:							
YSI	1 YES 2 NO	Inpatient 2 - ER/Outpatient	3 DOA 4 🗆	Nursing Home		8 Other (Specif)	)				
	27. MANNER OF DEATH  1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	RK?	28d. DESCRIBE H	IOW INJURY OCCU	RED			
BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY — At	home farm street		ES 2 NO	281 LOCATION (S	News and Mumber of	David David Market			
TED	4 Homicide determined	building, etc. (Specify)		ractory, office		City or Town,	State)	Rural Route Number,			
COMPLETED	290. CERTIFIER CERTIFYING PHYSICIAN	: To the best of my knowledge,	death occurred at the	he time, dete	and place, and due	to the enumeral on					
N N		n the basis of axamination and/									
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			BIONED (Month, Day, Year)			
) BE	Munger	(Spull)			O	673	D 6	5/22/95			
2	30. NAME AND ADDRESS OF PERSON WHO CO										
	SUDHI CHINTRISA	VA, MD 7	16 MA	IDEN	CHOICE	LANE,	CATONE	VILLE, MP.			
	31. DATE FILED (Month, Day, Year) 6/22/95 JUN 2:	32. REGISTRAR'S SIGNATURE 1995	tudierken	dall							
1 3	P/44/77 JUIN	y 1000 ()									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

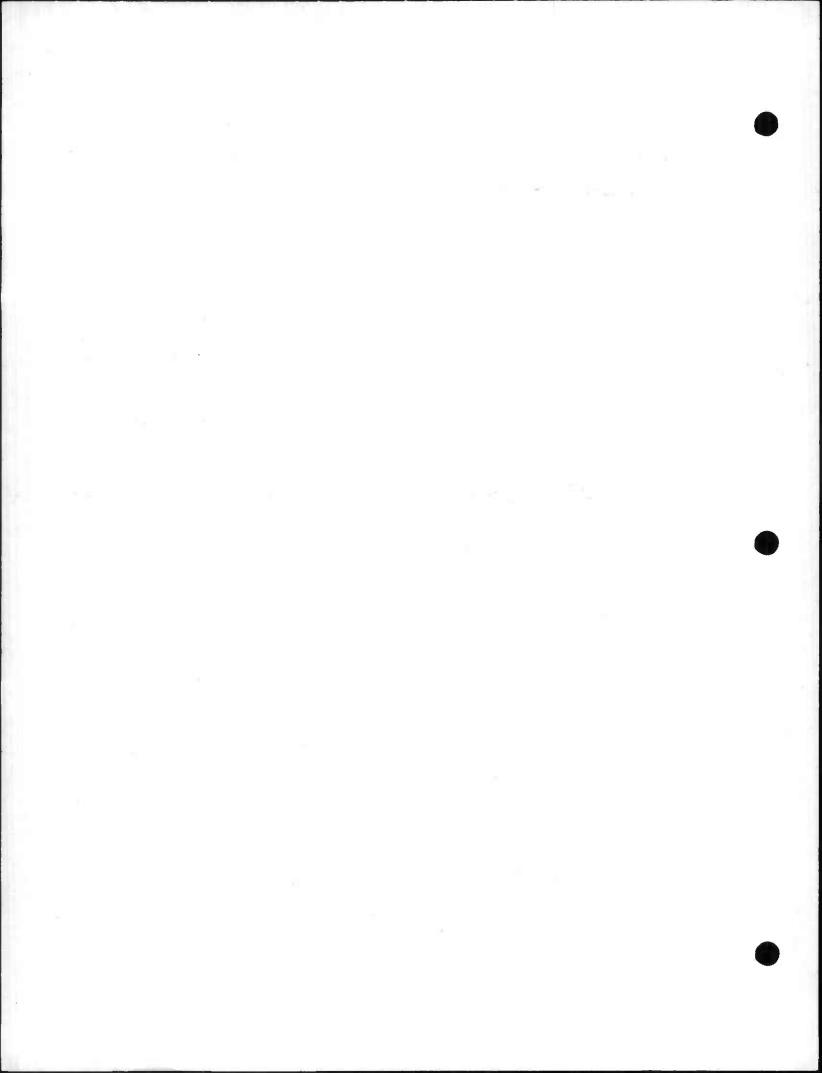
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

1		STATE REGISTRAR
	1. D	ECEDENT'S NAME

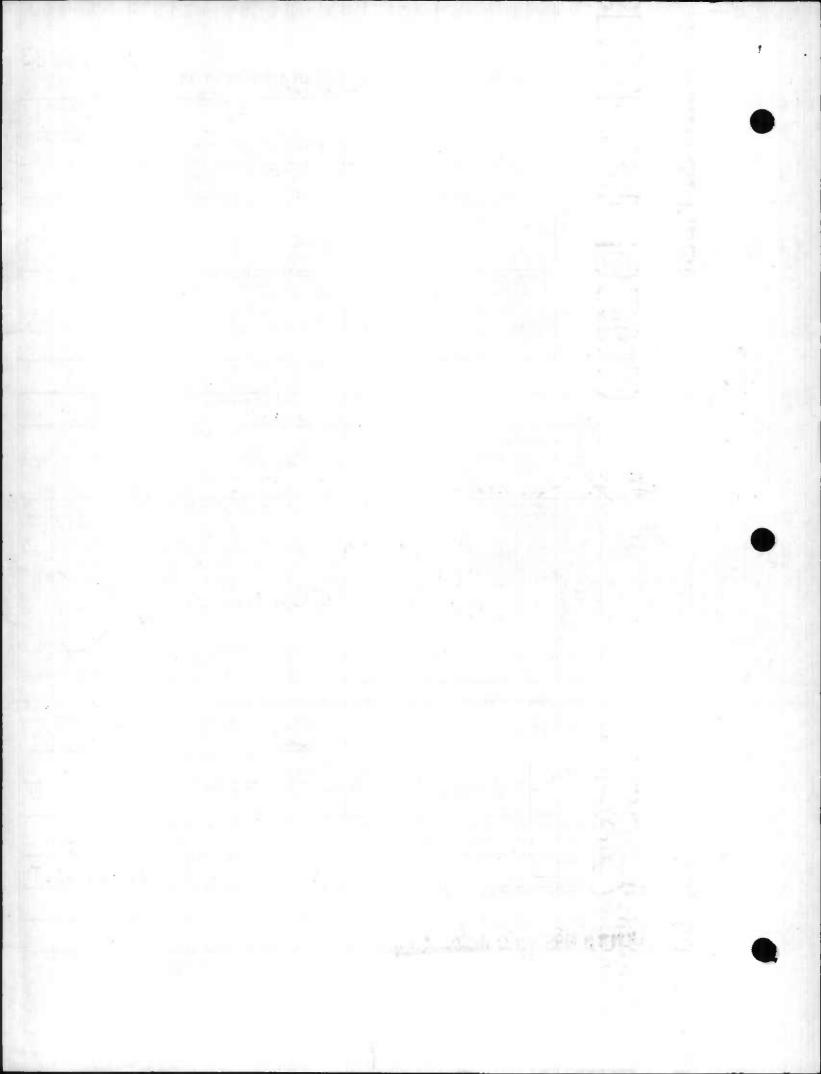
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. 0											
	DANTEL	LEE		CVIT	SHER		MON	E OF DEATH TH DA		EAR	. TIME OF DEATN
4.6	SOCIAL SECURITY NUMBER						Jun		199		0211
16	67-60-8060	1 X M 2 🗆 F	AGE (In yrs. les		ONTHS DAY		FEB	of BIRTH	2	ENN	ACE (State or Foreign SYLVANIA
	. FACILITY NAME (If not institution, give st	reet and number)		9	b. CITY, TOV	MN OR LOCATION OF			9c. COUNTY		TN
DIRECTOR 100 EE	Shock Trauma C	enter		Baltimore N/a							
100	. STATE 10b. COUNTY			10c, CITY,	TOWN OR LO	CATION			-	1	Od. INSIDE CITY
<u>ē</u> ₽er	<u>nnsylvania Centr</u>	<u>e</u>		Ple	asant	Gap				1	YES 2 NO
II.	STREET AND NUMBER					10f. ZIP CODE					AT COUNTRY?
<u> </u>	179 First Avenu					16823			U.S.		
	Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 I	YES 2 N	NO NO	If yes	DECENDENT OF NISP , specify Cuben, Mexi	can, Puerto	N? (Specify Yee Ricen, etc.)	or No — 14	Black, \	- American Indian, White, etc.
	☐ Widowed 4 ☐ Divorced	IF TES, GIVE WAR	JR DAIES		"י	YES 2 ND Spec	offy:		1	Specify:	WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(G)	CEDENT'S US	k done during	PATION most of working	16	b. KIND OF BUS	INESS/INDUS	TRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	We.	Do NOT usa r	etired.)					-	
17.1	FATNER'S NAME (First, Middle, Leet)			NEMAN_		40 4407117010 4				A CO	NSTRUCTI:
	ROBERT E. SWISHE	R				JEAN	(AME (First,	Middle, Maiden S	0 1 0 U I i	V	
190.	I. INFORMANT'S NAME (Type/Print)		198	b. MAILING AS	DORESS (Stre	eet and Number or Rura	I Route Nun		- 4		
2 R	OBERT SWISHER		1	79 FIR	ST AV	ENUE PLEA	SANT	GAP, P	ENNSY	LVAN	IA 16823
	. METHOD OF DISPOSITION  Burlel 2 Cremation 3 Remo	oval from State		AND DATE OF			1		ATION — City		
4 -	□ Donation 5 □ Other (Specify)		ÖÄKWÖ	OD'CRE				5/ <b>9</b> 5 ST			GE,PA.
20.	SIGNAFURE OF FUNERIAL SERVICE TO	1 Xac/1	/			E AND ADDRESS OF ISTALLINGS					DVI AND 2
23.	. PART I. Enter the diseases, or c	omplications that co	used the de	ath. Do not	enter the	mode of dving, au	Ch se car	rdiac or respir	SAULIVA	1, 11/1	Approximate
dis	shock, or heart failure. I MEDIATE CAUSE (Final sease or condition suiting in death)	Hum	PLE to	Munic	5						Onset and Da
If a can CA the	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  b.  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
											1
PA	RT II. Other eignificent conditions	contributing to dec	th but not re	eauiting in	the underl	ying couse given i	n Part I.	24a, WAS AN PERFORM	AED?	C	ERE AUTOPSY FINDIN MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
PAI							_	PERFORI	AED?	C	MILABLE PRIOR TO OMPLETION OF CAUSE
PAI	DID TOBACCO USE CONTR WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUS	E OF DEA	TH YES	□ NO	UNCERTA	_	PERFORI	AED?	C	MILABLE PRIOR TO OMPLETION OF CAUSI F DEATH?
PAI	DID TOBACCO USE CONTR		E OF DEA	TH YES	NO	UNCERTA	IN 🗆	PERFORI	AED?	C	MILABLE PRIOR TO OMPLETION OF CAUSI F DEATH?
PAI	DID TOBACCO USE CONTR WAS CASE REFERRED TO MEDICAL EXAMINER? Y YES 2 NO MANNER OF DEATH	HOSPITAL:    Inpetient 2\( \times \) ERIS (Myorin, Day, W	E OF DEA  28. PLAC  /Outpetient 3  URY bear)	TH YES	Check only of THER: Nursing P	UNCERTA	IN D	PERFORM  1 NAS 2  PERFORM  1 (Specify)  SCRIBE HOW IN	MED?	All Cri	MILABLE PRIOR TO DIMPLETION OF CAUSE P DEATH?
25. 1 27. I	DID TOBACCO USE CONTR  WAS CASE REFERRED TO MEDICAL  EXAMINER?  Y YES 2 NO  MANNER OF DEATH  I Netural 5 Pending Investigation	HOSPITAL:    Inpetient 2X ER     28e. DATE OF INUITABLE     1	E OF DEA  28. PLAC  /Outpetient 3  URY ber)	TH YES E OF DEATN DOA 4 28b. TIME C INJUR 0\05	NO Check only of THER: Nursing P F 28c.	UNCERTA  Nome 5 Residence  NJURY AT  WORK7  YES 2 NO	8 01h	PERFORM  1 NES 2  PER (Specify)  SCRIBE HOW IN	MED?	ALCO OF DED	MILABLE PRIOR TO DOMPLETION OF CAUSI F DEATH?  DATES 2 - NO
PA	DID TOBACCO USE CONTR WAS CASE REFERRED TO MEDICAL EXAMINER? Y 198 2 NO MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL:    Impetient 2X ER	E OF DEA  28. PLAC  /Outpetlent 3  VOIT PROPERTY  957  JURY — At hor	TH YES E OF DEATN DOA 4 28b. TIME C INJUR O\DS	NO Check only of THER: Nursing P F 28c.	UNCERTA  Nome 5 Residence  NJURY AT  WORK7  YES 2 NO	8 Oth 28d. DE 10000	PERFORM  1 (Specify)  SCRIBE HOW IN  CATION (Street ar or Town, State)	JURY OCCUR	ALED AREA ROU	MALBLE PRIOR TO DOMPLETION OF CAUSI F DEATH?  WES 2   NO
27. I	DID TOBACCO USE CONTR  WAS CASE REFERRED TO MEDICAL EXAMINER?  Y YES 2 NO  MANNER OF DEATH  1 Natural 5 Pending Investigation 6 Suicide 6 Could not be determined  CERTIFIER (Check only  CERTIFIER (Check only)  CERTIFYING PHYSIC	HOSPITAL:    Inpetient 2X ER    28a. DATE OF INITION     28a. PLACE OF	E OF DEA  28. PLAC  /Outpetient 3  Outpetient 3  URY — A1 hor (Specify)  D W A  knowledge, dea	TH YES E OF DEATN DOA 4 28b. TIME C INJUR NO 10 5 me, ferm, stra	NO Check only of THER: Nursing It Sectory, a	UNCERTA  Nome 5 Residence  INJURY AT  WORK?  YES 2 NO  office	8 Oth	PERFORM  1 (Specify)  SCRIBE HOW IN  CATION (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)	JURY OCCUR  OLL  OLL  OLL  ON  ON  ON  ON  ON  ON	ALCO ON THE PROPERTY OF THE PR	MILABLE PRIOR TO DOMPLETION OF CAUSI P DEATH?  WES 2 NO  NOTE 10 NO  NOTE 10 NO  NOTE 10 NO  NOTE 10 NO  NOTE 10 NO  NOTE 10 NO  NOTE 10 NO  NO  NO  NO  NO  NO  NO  NO  NO  NO
PAI PAI PAI PAI PAI PAI PAI PAI PAI PAI	DID TOBACCO USE CONTR  WAS CASE REFERRED TO MEDICAL EXAMINER?  Y YES 2 NO  MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  CERTIFIER (Check only one)  2 MEDICAL EXAMINER	HOSPITAL:    Inpetient 2X ER    28a. DATE OF INITION     28a. PLACE OF	E OF DEA  28. PLAC  /Outpetient 3  Outpetient 3  URY — A1 hor (Specify)  D W A  knowledge, dea	TH YES E OF DEATN DOA 4 28b. TIME C INJUR NO 10 5 me, ferm, stra	NO Check only of THER: Nursing It Sectory, a	UNCERTA  Nome 5 Residence  INJURY AT  WORK?  YES 2 NO  office  dete end piece, end du  n, death occured at the	IN 28d. DE LUCY Chy CR. See to the care of time, determined to	PERFORM  1 (Specify)  SCRIBE HOW IN  CATION (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)	JURY OCCUR  OLL  od Number or  20 CLL  ter se stated, due to the co	ACCION IN THE PROPERTY OF THE	MALBLE PRIOR TO MAPLETION OF CAUSE PEATH?  WES 2 NO  NOTE 10 NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE
PAI PAI 25. 0	DID TOBACCO USE CONTR  WAS CASE REFERRED TO MEDICAL EXAMINER?  Y YES 2 NO  MANNER OF DEATH  1 Natural 5 Pending Investigation 6 Suicide 6 Could not be determined  CERTIFIER (Check only  CERTIFIER (Check only)  CERTIFYING PHYSIC	HOSPITAL:    Inpetient 2X ER    28a. DATE OF INITION     28a. PLACE OF	E OF DEA  28. PLAC  /Outpetient 3  Outpetient 3  URY — A1 hor (Specify)  D W A  knowledge, dea	TH YES E OF DEATN DOA 4 28b. TIME C INJUR NO 10 5 me, ferm, stra	NO Check only of THER: Nursing It Sectory, a	UNCERTA  Nome 5 Residence  NJURY AT  WORK?  YES 2 NO  office  date end piece, end du  n, death occured at the  29c. LICENSE NE	IN 28d, DE LOCCHY  28f, LOCCHY  CRA se to the case time, deta	PERFORM  1 (Specify)  SCRIBE HOW IN  CATION (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)	JURY OCCUR  OLL   Id Number or   Id	ACCION IN THE PROPERTY OF THE	MALBLE PRIOR TO MAPLETION OF CAUSE PEATH?  WES 2 NO  NO NUMBER 10 NO NUMBER 10 NUMBER
27. I 27. I 1 2 3 4 4 29e.	DID TOBACCO USE CONTR  WAS CASE REFERRED TO MEDICAL EXAMINER?  Y YES 2 NO  MANNER OF DEATH  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  CERTIFIER (Check only one)  2 MEDICAL EXAMINER	HOSPITAL:  1   Inpetient 2X ER  28e. DATE OF INJ  (Month, Day, Y  EIAN: To the best of my  3: Dn the best of exami	E OF DEA  26. PLAC  26. PLAC  /Outpetient 3  URY ber)  9.5  URY — A1 hor (Specify)  N. D. W. A.  knowledge, dei	TH YES E OF DEATN DOA 4 28b. TIME C INJUR O 105 me, farm, stra	Check only of THER: Nursing P P Sec. I [ art, fectory, a the time, c, a n my opinion	UNCERTA  Nome 5 Residence  INJURY AT  WORK?  YES 2 NO  office  dete end piece, end du  n, death occured at the	IN 28d, DE LOCCHY  28f, LOCCHY  CRA se to the case time, deta	PERFORM  1 (Specify)  SCRIBE HOW IN  CATION (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)  A 1 (Street ar or fown, Stete)	JURY OCCUR  OLL   Id Number or   Id	ACCION IN THE PROPERTY OF THE	MALBLE PRIOR TO MAPLETION OF CAUSE PEATH?  WES 2 NO  NO NUMBER 10 NO NUMBER 10 NUMBER





	1. DECEDENT'S NAME (First, Middle, Last)  Josephine Marie	Steiner			d &		MONT	OF DEATH	1005	TEAR 3.	TIME OF DEATH	
	4. SOCIAL SECURITY HUMBER		3. AGE (In yrs. lest birthde)	y) IF UNDER 1	VEAD T	IF UNDER 24 HRS.	Jun	е 18,	1995	BURTHEN	10:31 ACE (State or Fore	
	214-03-4906	1 🗆 M 2 💢 F	82 YRS.	MONTHS	DAYS	HOURS MIN.	Feb	h, Day, Year)	913 B	alti	more	
CTOR	96. FACILITY NAME (If not institution, give a Madonna Heritage RESIDENCE OF DECEDENT		Home			Sville	EATH		Har	ford	гн	
DIREC	10e. STATE 10b. COUNT	timore	10c. C	Kings			A				IHSIDE CITY LIMITS?	
FUNERAL	100. STREET AND NUMBER 2813 Brockton Di	rive		10f. ZIP CODE 21087					10g. CITIZEH OF			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	EVER IH U.S. ARMED YES 2 NO R OR DATES	2 NO If yes, specify Cuben, Mexican, I						Specify:	American Indiar		
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12th.	(Give kind o	6e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16b. KIHD OF B									
COMPL	17. FATHER'S HAME (First, Middle, Last)	Housew	Housewife Homekeeping  18. MOTHER'S HAME (First, Middle, Meiden Surneme)									
ECC	Rudolph Hruz		18. MOTHER JUL:						oumente)			
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILH	NG ADDRESS	(Street ar	nd Number or Rural	_		n, State, Zip Co	ode)		
5	Mrs. Arlene R. H:	ildebrandt									87	
	Mrs. Arlene R. Hildebrandt 2813 Brockton Drive Kingsville, Md  200. METHOD OF DISPOSITION  1 M Buriel 2 Cremation 3 Removal from State  4 Donotton 5 Other (Specify)  201. PLACE AND DATE OF DISPOSITION (Name of committee), or other piece)  Most Holy Redeemer Cem. June 21, 1995 Baltim										, state Md .	
	Most Holy Redeemer Cem. June 21,1995 Baltimore, Md.  21. SIGHATURE OF FUHERAL SERVICE LICENSEE  E. F. Lassahn Funeral Home 11750 Belair Road Kingsville. Md.2											
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initiated eventa resulting in death) LAST  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
		d		The state of the s		but not resulting in the underlying ceuse given in P						
DICAL CE	PART II. Other aignificant condition	ne contributing to d	eath but not resultin	g in the und	derlying	) ceuse given in	Part I.	24a. WAS AN PERFOR	RMED?	AA CI	MILABLE PRIOR	
MEDICAL CE	PART II. Other significant condition	ne contributing to d	eath but not resultin	g In the und	derlying	ceuse given in	Part I.	PERFOR	RMED?	CO	MILABLE PRIOR 1 OMPLETION OF C F DEATH?	
MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER	26. PL	ACE OF DEATH (C)	reck only o	PERFOR	RMED?	CO	ERE AUTOPSY FIN MILABLE PRIOR 1 OMPLETION OF CI F DEATH?	
PHYSICIAN: MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Return 5 Pending	HOSPITAL:	ER/Outpatient 3 DOA	OTHER:	26. PL: ing Home 28c. IHJU WOI	ACE OF DEATH (C)	s Coth	PERFOR	NO NO	AM CCC OCC	MILABLE PRIOR 1 OMPLETION OF G F DEATH?	
ED BY PHYSICIAN: MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 760 27. MANNER OF DEATH	HOSPITAL: 1   Inpetient 2   1 28e. DATE OF It (Month, Day)	ER/Outpetlent 3 DOA  1JURY Year)  INJURY — At home, ferm	OTHER: 4   Hursh Time OF   2 INJURY   M	26. PL i: ling Home 28c. IHJU WOI 1  Y	ACE OF DEATH (CF)  5 12 Residence URY AT RKY TES 2   HO	s Other	PERFOR	NJURY OCCU	AN CC OI 1	MILABLE PRIOR 1 MPLETION OF C F DEATH? YES 2 H	
ETED BY PHYSICIAN: MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined  29e. CERTIFIER (Check only	HOSPITAL: 1 Inpetient 2 Inpeti	ER/Outpetlent 3 DOA  1JURY Year)  INJURY — At home, ferm	OTHER: 4   Hursin	26. PL: ing Home 28c. IHJU WO 1  Y Ny, office	ACE OF DEATH (CF)  5 I Residence URY AT RK?  (ES 2 HO)  end place, end due	s Other	PERFOR  1 YES 2  NY (Specify)  SCRIBE HOW I  CATION (Street or Town, Stele)	NJURY OCCU	RED Rural Rou	MILABLE PRIOR TO MAPLETION OF CLEATH?  YES 2 H	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   YO  27. MANNER OF DEATH 1   Netural 5   Pending Investigation 3   Suicide 8   Could not be determined  29e. CERTIFIER (Check only one) 2   MEDICAL EXAMINE  29b. SIGNATURE OF THE CONTRIBUTE OF CERTIFIER	HOSPITAL: 1   Inpetient 2   1 28e. DATE OF It (Month, Day) 28e. PLACE OF building, et	ER/Outpatient 3 DOA  JURY  Year)  INJURY — At home, ferme, (Specify)  ry knowledge, death occumination end/or investigations.	OTHER: 4 Hursh TiME OF INJURY M n, street, factor urred at the tim stion, in my opi	26. PL: ing Home 28c. IHJU WO 1  Y Ny, office	ACE OF DEATH (CF)  5 I Residence URY AT RK?  (ES 2 HO)  end place, end due	28d. DE  251, LOCCity  to the ca	PERFOR  1 YES 2  IN (Specify)  SCRIBE HOW 1  CATION (Street or Town, Stele)  use(s) end mere end place, en	NJURY OCCU	RED Rural Rou	MILABLE PRIOR TO MAPLETION OF CLEATH?  YES 2 H	
ETED BY PHYSICIAN: MEDICAL CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	HOSPITAL: 1   Inpetient 2   I 28e. DATE OF It (Month, Dey, 28e. PLACE OF building, et  ER: On the best of m ER: On the best of exa	ER/Outpetlent 3 DOA  AJURY Year)  INJURY — At home, ferm ic. (Specify)  Ry knowledge, death occumination end/or investigate  OF DEATH (ITEM 27) (7)  Lair Road	OTHER: 4 Hurshi FiME OF INJURY M  In, street, factor  urred at the tim  titlon, in my opi	26. PL: Ing Home 28c. IHJI WO  Pry, office me, date	ACE OF DEATH (C)  • 5 Pasidence UNY AT RK?  ES 2 HO  end place, end due eath occured at the	251. LOC City  to the case Hime, determined t	PERFOR  1 VES 2  NO (Specify)  SCRIBE HOW I  CATION (Street or Town, Stele)  use(e) end men	NO NO NO NO NO NO NO NO NO NO NO NO NO N	RED Result Rou  Cause(e) e	MALABLE PRIOR OMPLETION OF CF DEATH?  YES 2 1  No Number,  No Number,  No number,  No number,  No number,	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

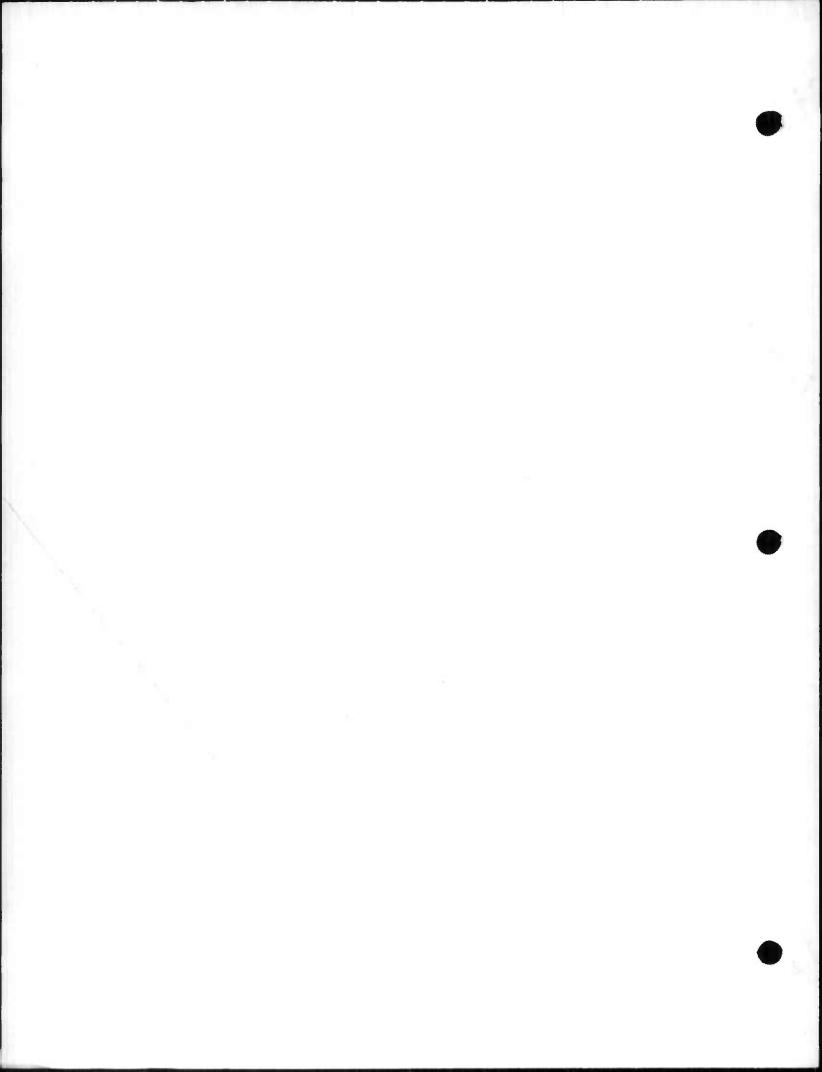
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item#1.G-film724 p				TMENT	OF H	IEALTH	AND I	MENTAL HYGIEI	_		10324
	REGISTRAR		CE	RTIF	ICATE	OF	DEA	TH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)  ELIZABETH	eWeese	S	TROC	K					DAY	YEAR 1995	2:50 p M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las		IF UNDER	_	IF UNDER		7. DATE OF BIRTH	. /	8. BIRTNI	PLACE (State or Foreign
	213-48-0033	1 🗌 M 2 💢 F	76	YRS.	MONTHS DAYS HOURS MIN. (Month, Day, Year)  June 4, 1910					919	Country	York
~	Se. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	TOWN C	R LOCATI	ON OF DE		EATH		
Ď	GREATER BALTIMORE	MEDICAL	CENTER		TOWSON					E		
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION			10d. INSIDE CITY		
	Maryland Balt:	imore Co	untv		To	WSO	n				- 1	LIMITS?
ME	10e. STREET AND NUMBER		,			10f	ZIP COD	E		10g. CI	TIZEN OF W	THAT COUNTRY?
FUNERAL	1055 West Joppa						2:	1204		U	SA	
FU	11. MARITAL STATUS	FORCES?	T EVER IN U.S. AR	MED	13. V	WAS DEC	ENDENT C	OF HISPAN	IC ORIGIN? (Specify Yen, Puerto Rican, etc.)	a or No	14. RACE Black	American Indian, White, etc.
BY	3 Widowed 4 Divorced		MR OR DATES				2 X NO				Specif	
ED	15. DECEDENT'S EDUC	CATION	16a. DE		USUAL OC				18b. KIND OF BU	JSINESS/IN	DUSTRY	
LET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT us				10				
COMPLETED		5+	Pres	schoo	ol Te	ache	er		Educ	atio	n	
	17. FATHER'S NAME (First, Middle, Last)	a	D 11				100		ME (First, Middle, Meider	-		
BE	Dwight Davi	u	DeWee		A DODESO	(0)		ldre	Poute Number, City or Tox	Merri	11 D	ickson
2	Mr. Ralph Lawrer	ice Stroc										24.224
	20a. METHOD OF DISPOSITION		20b. PLACE	IND DATE	OF DISPOSI	TION (Na	me of	DBO	Towson	Mary OCATION -	City or Toy	217()4 vn. State
	1 Burial 2 Cremetion 3 Remo	ovel from State	cometery, crea	matory or o	ther place)							
	21. SIGNATURE OF FUNERAL SERVICE LOC	ENSEE			22. P	IAME AN	D ADDRE	SS OF FA	CILITY		LCGIR	aryrand
	Martin D. Van	Mitchell-Wiedefeld Home 6500 York Road, Baltimore, MD 2121									212	
	23. PART I. Enter the diseases, or o	omplications the	t coused the de	ath. Do r	not enter	the mo	de of dyl	ng, auci	h as cardiac or reap	dratory a	TO ZI.	Approximata
	ahock, or heert fellure. I	List only one cet	use on each line.		٨							Interval Between Onset and Death
	disease or condition resulting in death)	DUE TO	rkin	SON	-5							100
		DUE TO	(OR AS A CONSEC	DUENCE OF	F):		-					104
ON	Sequentially list conditions,	DUE TO	(OR AS A CONSEC	UENCE O	D.			_				
E .	if any, leading to immediate cause. Enter UNDERLYING	552.10	(OIT AS A CONSEC	OENCE O	٦٠.							
CERTIFICATION	CAUSE (Disease or injury thet initieted events	DUE TO	(OR AS A CONSEC	UENCE O	F):							
ᇤ	resulting in death) LAST	ı										
	PART II. Other algorificent conditions	contributing to	deeth but not re	esuiting i	in the unc	derlying	Ceuse C	iven In	Part I. 24s, WAS AN	AUTOPSY	T 24b.	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA	h/o P.E.	AS	CVD	>					PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									'   '   '	Z LYNU	- 1	OF DEATH? 1 ☐ YES 2 ☐ ATO
ž	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEAT	TH YE	S 🗆 N	10 🗆	UNC	ERTAIN	10			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	N (Check o							
IXSI	1 TYES 2 TNO	1 Inpatient 2	ER/Oulpatient 3		-		5 🗆 Re	aldence	6 Other (Specify)			
	27. MANNER OF DEATH  1: Natural 5 Pending	28a. DATE OF (Month, D	ay, Young	28b. TIM INJ	E OF URY	28c. INJU WOI	RK?		28d. DESCRIBE NOW	INJURY OC	CURED	
B	2 Accident Investigation 3 Suicide & Could not be	26a, PLACE C	F INJURY At hor	ne, faceli, a	treel facto		ES 2 [	NO	26f. LOCATION (Street	and Number	a or Dumi Da	de Alemba
6	4 Homicide 6 Could not be	building,	atc. (Specify)			19, 011100			City or Town, State	)	r or manur mo	oute Number,
J.E	29a. CERTIFIER 1 CERTIFYINO PHYSIC	AN: To the best of	my knowledge, dea	nth occum	ed at the tir	ne date	and place	and this	to the cause(a) and me		444	
COMPLET									to the cause(a) and me lime, date and place, a			and manner as stated,
	29b. SIGNATURE AND TITLE OF CERTIFIER		11					NSE NUM				(Month, Day, Year)
38 C	1	L	M					13	41104	<b>&gt;</b> 1	1	195
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAU	SE OF DEATH (ITEM	27) (Type,	Print)	V	-(1.	D	10	1.1	111	2 (0/1)

32. REGISTRAR TO IGNATURE

JUN 2 3 1995



BALTIMORE, MARYLAND 21215-0020

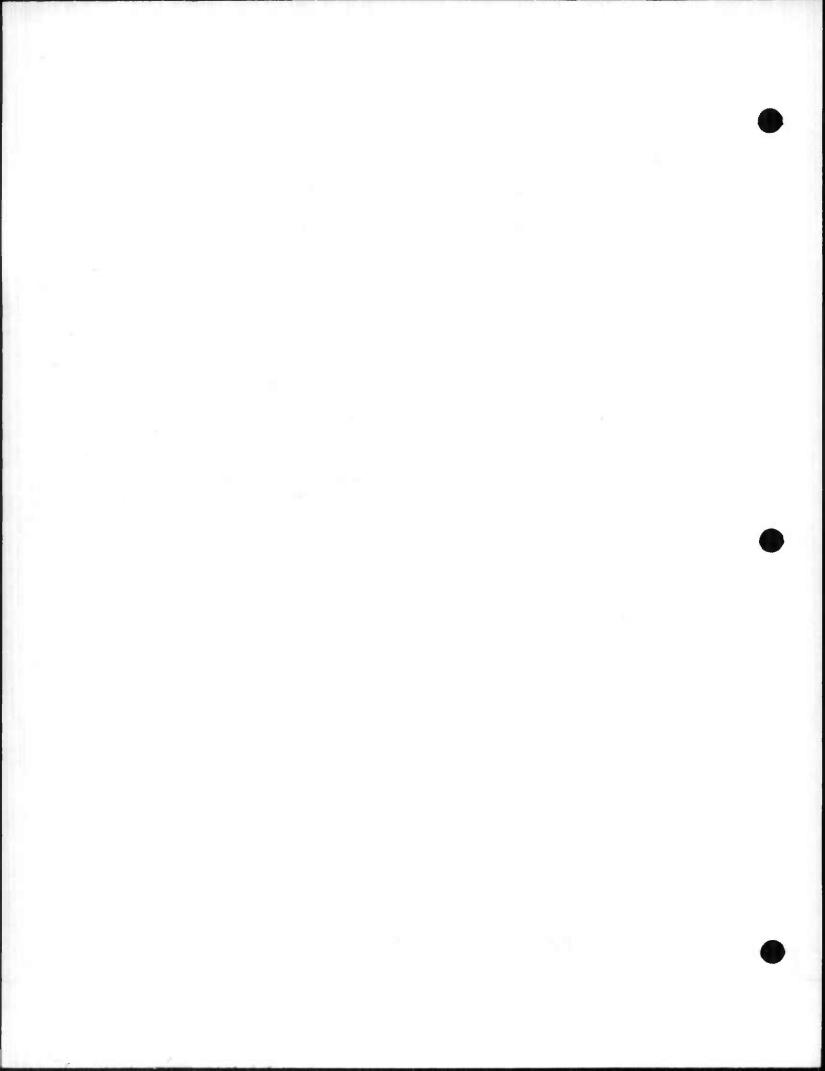
DIVICION OF

1 - FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPARTMENT CERTIFICATE
1. DECEDENT'S NAME (First, Middle, Lest)  V / N C E N 7	WILLIA	M STARKE
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday) IF UNDER

OF HEALTH AND MENTAL HYGIENE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,									2. DATE OF	DEATN			3. TIME OF DEATH
	VINCEN	17	WILLIAM	1 1	TAR	KE				JUN	DA		YEAR	1:15 AM
	4. SOCIAL SECURITY NUME			6. AGE (In yrs. ia			R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	-	7 /	-	LACE (State or Foreign
	423-03-691	17	1 M 2 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, E	Day, Year)		Country)	
	9e. FACILITY NAME (If not in		net and number)	OI		9b, CITY	/. TOWN	OR LOCATI	ON OF DI		-1914		V1r	ginia
E I	Good Samari							timo				st. 000	1	110
5	RESIDENCE OF DEC	EDENT					Dai	CIMO.	16				10	117
DIRECTOR	10e, STATE	10b. COUNTY			10c, CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
	Maryland	Balti	more			Lutherville						1 YES 2 XNO		
₹ I	10e. STREET AND NUMBER				10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL		edgewoo			21093						U.S.A			A.
E	11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1 [	EVER IN U.S. AF	RMED NO	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.)						14. RACE — American Indian, Black, White, etc.		
B≺	1 Never Married 2 Married IF YES, GIVE WAR OR DATES X					1 YES 2 NO Specify:						Specify	White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) ((6.1)					USUAL O	CCUPATIO	DN .		16b. K	IND OF BUS	INESS/INC	OUSTRY	
<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5 +)					work done se retired.)	during mo	st of working	ng					Page 1
MP						or				St	arke	Real	lty	100
8		17. FATNER'S NAME (First, Middle, Last)						16. MOTI	NER'S NA	ME (First, Mid				
BE	William		derick	Starke				1	Lura	Li	llia	n Hi	icks	
2	19e. INFORMANT'S NAME (7)			19					or Rural i	Route Number,	City or Town	, State, Zip	Code)	
-	Marie B.				San	ne As	5 #1	0						
	20a. METHOD OF DISPOSITI	n 3 🗆 Remov	al from State	20b. PLACE	AND DATE (	OF DISPOS	SITION (No	rme of		DATE			City or Tow	
	4 <sup>(1)</sup> Donation 5 □ Other			Loud	on Pa	-					Ba	ltimo	ore, 1	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Ruck Towson Funeral Home, Inc.													
	- wa	Mac	e S-12	sloos	110	71.	050 Vork Pond Morroon Md 21204							
	23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Approximata			
i	snock, or heart failure. List only one cause on each line.										Onset and Death			
	disease or condition	+	SEP	515										30AYS
	,			OR AS A CONSE		F):								
N	Sequentially list conditi	one b.		umoni								6 DAYS		
CERTIFICATION	If any, leading to immed cause. Enter UNDERLY	diate	DUE TO (C	OR AS A CONSE	SEQUENCE OF):									
5	CAUSE (Disease or inju		DUE TO #	OR AS A CONSE	OHENCE OF	D.								
Ē	that initiated events resulting in death) LAS	г	002 10 (1	AN AS A CONSE	OUENCE U	r):								i .
Ë		d.												
4	PART ii. Other algnifica	nt conditions	contributing to d	eeth but not i	reaulting	n the ur	derlying	ceuse g	lven in	Part i. 24	a. WAS AN			VERE AUTOPSY FINDINGS
MEDICAL	C DIFF C	OLITIS								PERFORI			MAILABLE PRIOR TO COMPLETION OF CAUSE	
ij	MYOCARDIA	11 INF	ANCTION							_   '	4			F DEATN?
ΞI	DID TOBACCO U	SE CONTRI	BUTE TO CAU	ISE OF DEA	TH YE	S 🗆 I	NO [	UNC	ERTAIN	V D				
ĕ.	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			CE OF DEAT	TH (Check	only one)							
Š	1 TYES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Re	aldence	6 Other (S	(pecify)			
PHYSICIAN:	27. MANNER OF DEATH		26e. DATE OF III (Month, Day		28b. TIM	E OF URY	28c. INJ	URY AT RK?		28d. DESCR	IBE NOW IN	JURY OC	CURED	
BY		Pending rivestigation				М	1 🗆 1		NO					
	3 Sulcide 8 1	Could not be	28e. PLACE OF building, et	INJURY — At ho	ome, term, s	treet, fact	ory, office			28t. LOCATIO	ON (Street el	nd Number	or Rural Roo	ute Number,
Ë I	4 Homicide	determined									,,			
ᆲ	290. CERTIFIER (Check only	IFYING PHYSICI	AN: To the best of m	y knowledge, de	eth occurre	d at the t	ime, dete	end place,	end due	to the ceuse(	e) end men	ner ee stat	ed.	
COMPLETED														and manner se stated.
	29b. SIGNATURE AND TITLE							29c. LICE	NSE NUN	BER	1	29d. DATI	E SIGNED /A	fonth, Day, Year)
BE	grecustru							p	08	235	[			19,1995
유	30, NAME AND ADDRESS OF											_		
	ROWENA CAST	RENCE,	m.D. 60	OD SAM	ARITAI	N HOS	PITA	L 560	01 60	CHRAV	EN B	LVD !	BALTIM	10RE 21739
	JUN 2	3 1995	32. DEGISTRAR	S SIGNATURE	rdall									

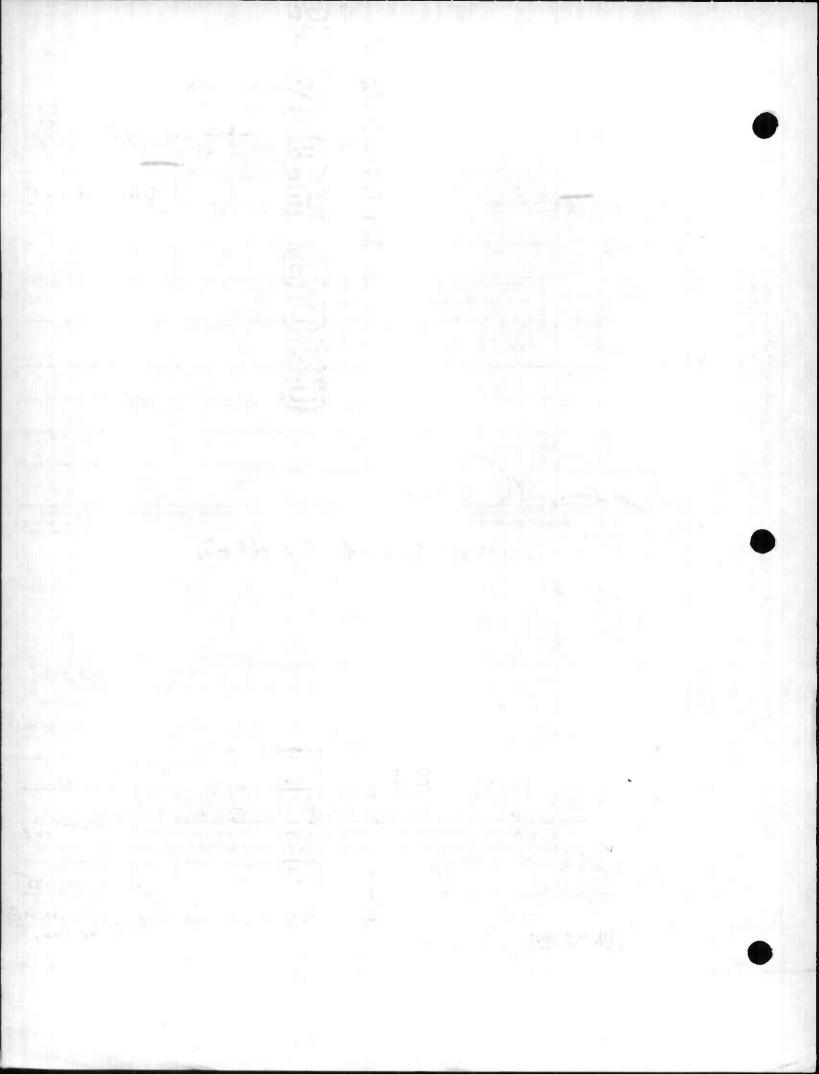
DHMH-16 Rev 1/89



JUN 2'3 1995

	1, DECRIDENT'S NAME (FI	FTH	Theod	oke T	TA 62	ER	OF			ATE OF DEATH	DAY	YEAR	TIME OF DEATH	
	4. SOCIAL SECURITY NUI 214-36-7		5. SEX	6. AGE (In y	yrs. lest birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 H	. (4	ate of Birth Month, Day, Year) 1 une30	1937	Country)	LACE (State or Foreign	
TOR	9a. FACILITY NAME (If not	N/A55	street and number) 54 Carvi		enue	33		tus			9c. COMNT	Y OF DEA		
DIRECTOR	10a. STATE Maryland	10b. COUNT	timore		10	y, TOWN C		TION					IOd. INSIDE CITY	
	100. STREET AND NUMBE	ER						. ZIP CODE		10g. CITIZEN			1 TYES 2 X NO	
FUNERAL	5554 Cary	ville	Avenue	MIT F1/F0 (1) II				21227					States	
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ETED		ECEDENT'S ED			Se. DECEDENT'S (Give kind of life. Do NOT us	work done				16b. KIND OF BU	USINESS/INDU	STRY		
COMPLET	12		+2	**/	owner			7.4		pai	int s	tore		
	17. FATHER'S NAME (First, Ralph Ta									irst, Middle, Maide				
BE	19a. INFORMANT'S NAME				19b. MAILING	ADDRESS	(Street e			Gosne		Code)		
5	Anna Tab	oler			5554	Ca	rvi	lle A	venu	e Arbu	itus :	2122	27	
	20a. METHOD OF DISPOS 1 ☐ Burtel 2 Å Creme	SITION Non 3 - Res	noval from State		LACE AND DATE	OF DISPOS	ITION (Na	ime of		DATE 20c. L	OCATION - CI	ity or Town	n, State	
	4 Donation 5 Oth		course /	-		oma	tor	y	6/	24 Cat	onsv	1116	. bM.	
	25. SIGNATURE OF PORE	HAL SCHVICE L	L SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Ambrose Funeral Home 1328 Sulphur Spring Road						nbr	ose F	iner	al Hom	ne	Ar	butus	
	1	0	37			) A	mbr (	Sulp	uner nur	Sprine	ne TRoad	Ar d 21	butus 227	
(	11	heart fallure	complications th	nat caused the	ha daath. Do	) A	mbr (	Sulp	uner nur	Sprine	ne TRoad	Ar d 21	227 Approximate Interval Bate	
6	23. PART I. Enter the ahock, or iMMEDIATE CAUSE (I disease or condition resulting in death)	heart fallure	complications the List only one can be as a Due to	nat caused the suse on aact	ha daath. Do	) A	mbr (	Sulp	uner nur	Sprine	ne TRoad	Ar d 21	227 Approximate Interval Bate	
ATION	ahock, or IMMEDIATE CAUSE (I disease or condition reaulting in death)  Sequentially list cond if any, leading to imm	heart fallure	a. Short	T9 V NO (OR AS A CO	ha daath. Do	not entar	mbr (	Sulp	uner nur	Sprine	ne TRoad	Ar d 21	227 Approximate Interval Bate	
ERTIFICATION	ahock, or IMMEDIATE CAUSE (I disease or condition reaulting in death)	dittiona, nedlate LYING	a. Short DUE TO	T 9 V A O (OR AS A CO	ha daeth. Do d h lina. ONSEQUENCE O	A) 1 1 not entar	mbr (	Sulp	uner nur	Sprine	ne TRoad	Ar d 21	butus	
MCAL CERTIFICATION	shock, or iMMEDIATE CAUSE (I disease or condition reaulting in death)  Sequentially list condition if any, leading to immicause. Enter UNDERL CAUSE (Disease or in that initiated events	dittiona, nedlate Lyling jury	a. She to DUE TO DUE DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DU	T 9 V M O (OR AS A CO O (OR AS A CO	he deeth. Do on h line.  ONSEODENCE O  ONSEOUENCE O	A) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	tha mo	ose r Sulp de of dying,	unernur auch as	Spring cardiac or reap	N AUTOPSY PRIMED?	Ar 21 at,	Approximate Interval Battonset and E	
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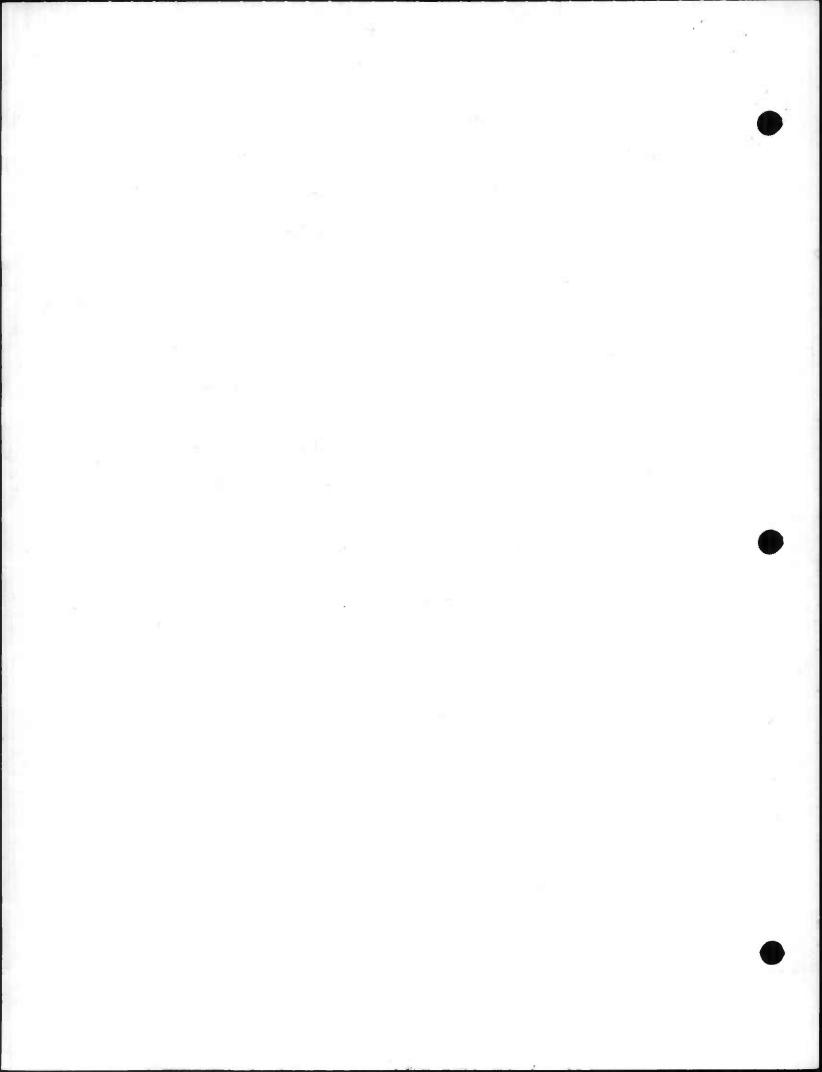
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CER	TIFIC	ATE OF	DEATH		REG. NO.						
- 8	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF MONTH			VEAR	3. TIME OF DEATH			
	MARY V. UHLHORN						JUNE	20	, 1	995	7:30 A M			
	4. SOCIAL SECURITY NUMBER 218-10-1402		AGE (In yrs. lest bir		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, E AUG . 2.	lay, Your)	4	Countr	IPLACE (State or Foreign y) YLAND			
NG.	9e. FACILITY NAME (If not institution, give s 47 S. CARROLLTON			96	96. CITY, TOWN OR LOCATION OF DEATN BALTIMORE  9c. COUNTY OF DEATN BALTIMORE						EATN			
5	RESIDENCE OF DECEDENT								L					
DIRECTOR	MARYLAND BA		ITY "	De. CITY, TO	OWN OR LOCA	BALTIMOR	RE				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 47 S. CARROLLTON	AVENUE			10	21223	1			U.S.	VHAT COUNTRY?			
3	11. MARITAL STATUS	12. WAS DECEDENT EV	/ER IN U.S. ARMED	)	13. WAS DEC	ENDENT OF HISPA		Specify Vee			— American Indian.			
BY	1 Never Married 2 Narried 3 Wildowed 4 Divorced	FORCES? 1 []			If yes, sp	ecify Cuban, Maxica 2 NO Specif	nn, Puerto Rici	m, etc.)		Speci	, Whita, etc.			
밀	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give k	ind of work	JAL OCCUPATION	ON st of working	16b. KI	ND OF BUS	INESS/INI	DUSTRY				
COMPLETED	Elementary/Secondary (0-12) H/S GRAD	College (1-4 or 5+)	He. Do	NOT use re	tired.) T MANA		BAT	Z ISL	AND	SEAF	OOD			
<b>∑</b>	17. FATNER'S NAME (First, Middle, Last)					18. MOTHER'S NA				DEITE	002			
BEC	HARVEY HICKS					LOLA	MAE BI	ELL						
٩	190. INFORMANT'S NAME (Typo/Print)  MR. FRANK UHLHOR	N	19b. M.	S. C	ARROLI	nd Number or Rural TON AVEN	Route Number,	City or Town	, State, Zip MORE	, MD	21223			
	20s. METHOD OF DISPOSITION  1  Burlel 2  Cremetion 3  Rem  4  Donation 5  Other (Specify)	oval from Stata	20b. PLACE AND cemetery, cremato LOUDON	LACE AND DATE OF OISPOSITION (Name of page 20c. LC						OCATION — City or Town, State LTTMORE				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC.										
	> M. Tleaf	Colens			4107	VILKENS .	AVENUE	- BA	BALTIMORE, MD 21229					
	23. PART . Enter the diseases, or canock, or head failure.  IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	List only one ceuse	on each line.								Approximata Interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUEN	NCE OF):	inc (	JARD	IOUAS	CUL F	HZ	V	STASE			
- 1	PART il. Other significent condition	a contributing to dea	th but not recu	Iting in th	a underlyle	s device alves la	Bout I a	a. WAS AN A	a remain	1				
<u>8</u>	CARCINOMA	OF	THE 1	DWU	G	Couse given in		PERFORE	ALIE!	240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MED	CARCINOMA	OF .	THE	Dec	JUK1	1	_   '	U YES	J.wo		OF DEATH? 1 YES 2 NO			
	DID TOBACCO USE CONTI	RIBUTE TO CAUS	E OF DEATH		□ NO D	UNCERTAIL	N 🗆	-	•					
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER	HOSPITAL:	26. PLACE OF		Check only (Me)	1								
PHYSI	1 TYES 2 10	1 🗆 Inpetient 2 🗆 🖽	4	00A 4 E	Number Hom	CONTRACTOR OF THE PARTY OF THE	6 Other (S							
ВУ РН	27. MANNER OF CANAL STREET STR	26a. DATE OF HUMAN	20	b. TIME OF	28c. INJ W0		28d. DEŞCR	IBE HOW IN	JURY OC	CURED				
	3 Suicide 8 Could not be date milined	28e. PLACE OF IN. building, etc.	JURY — At home, (Specify)	farm, stree	t, factory, offic		28f. LOCATIO	ON (Street ar	nd Number	or Rural R	oute Number,			
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSH										and manner se stated			
BEC	296. SUGNATURE AND TITLE OF CERTIFIER		1	)		29c. LICENSE NUI				-	(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM 27)	(Type, Prin	t)	DUS	16	7	<b>&gt;</b>	72	2445			
	DR. JINET HORN	- 1075	5 FALLS	ROAD	- SUI	TE 310 -	LUTHE	ERVIL	LE,	MD 2	21093			
	31. DATE FILED Month, Day, Year)	32. REGISTRAR'S	SIGNATURE											

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D. BOX 68760	OCCUTAL OR ATTENDING PHYSICIAN. The law requires that the death partificate he executed within 34 brune other
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DIVISION OF VITAL RECORDS, P.O.	radinira
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Constance Olia Wilson June 07 1995 45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 6. BIRTHPLACE (St IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Cct. 9, 192 212-26-9995 1 M 2 KF HOURS Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NIA maryland General Hospital Baltimore 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MC Alm ALTIMORE 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21239 funeral director, page 5 should be detached for use as the burial-transit NOTEUN HUE. USA Page 6 may be retained by the hospital or attending physician. tt. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.)
t YES 2 NO Specify: t4. RACE — American Indian, Black, White, atc. Never Married 2 Merried Specify: BIACK BY 3 Wildowed 4 Divorced COMPLETED ts. OECEDENT'S EDUCATION ecify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION t6b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 2+4 NA tssistant 17. FATHER'S NAME (First, Migdle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surn. 23 406 112ABETH ADAMS BE notified 2 HOWARD BROWN k Ave. 21507 9 METHOD OF DISPOSITION PLACE AND DATE OF DISPOSITION 20c. LOCATION — City or Ton Mem Pk. DATE Must Burlei 2 Cremetion 3 Removal from State 410/9 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTO. n by the f MD 21215 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, auch as cardisc or reapiratory strest, abock, or healt fellure. Liet only one cause on each line. n and completely filled in by to burial, cremation, or remov Approximats Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death 中 disease or condition Cardiac arrhythmia unknown event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Ischemic cardiomyopathy traumatic CERTIFICATION 1974 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate physician prior Pulmonary hypertension cause. Enter UNDERLYING CAUSE (Disease or injury 1988 other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atter Mental PART II. Other significent conditions contributing to deeth but not reculting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? and and shows any signed I 1 YES 2X NO OF DEATH? 1 | YES 2 | NO Deen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL:
1 M Inpatient 2 ER/Outpatient 3 DOA 1 YES 2 100 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF CEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with c marked. 1 Natural 5 Pending t YES 2 NO BY After t 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) .00 6 Could not be COMPLETED DIRECTOR: hours after 4 Homicide 28 determined 1 🛣 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, data end place, end due to the cause(s) and manner as steted. TO THE HOSPITAL OF THE FUNERAL COMPOSITION TO THE FUNERAL COMPOSITION TO THE FUNERAL THE F 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE abrane Mairanghous 39224 June 7,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tatiana Mouravskaia, MD c/o Maryland General Hospital 827 Linden Ave



FilmG, 724, item #1,16a, 6/23/95, cyw per f.h.

iner must be notified at once.

Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

permit. and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. è examiner medicai 6 the other traumatic event, burial, Hygiene prior to 0 signed by the shows any this certificate has been a with the State Dept. of 23 DR ATTENDING PHYSICIAN: 5 marked, death y DIRECTOR: I 28 TO THE HOSPITAL OF THE FUNERAL CORE FILED WITHIN 72 has IMPORTANT: If It HOSPITAL

CERTIFICATION

MEDICAL

PHYSICIAN:

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COMPLETED

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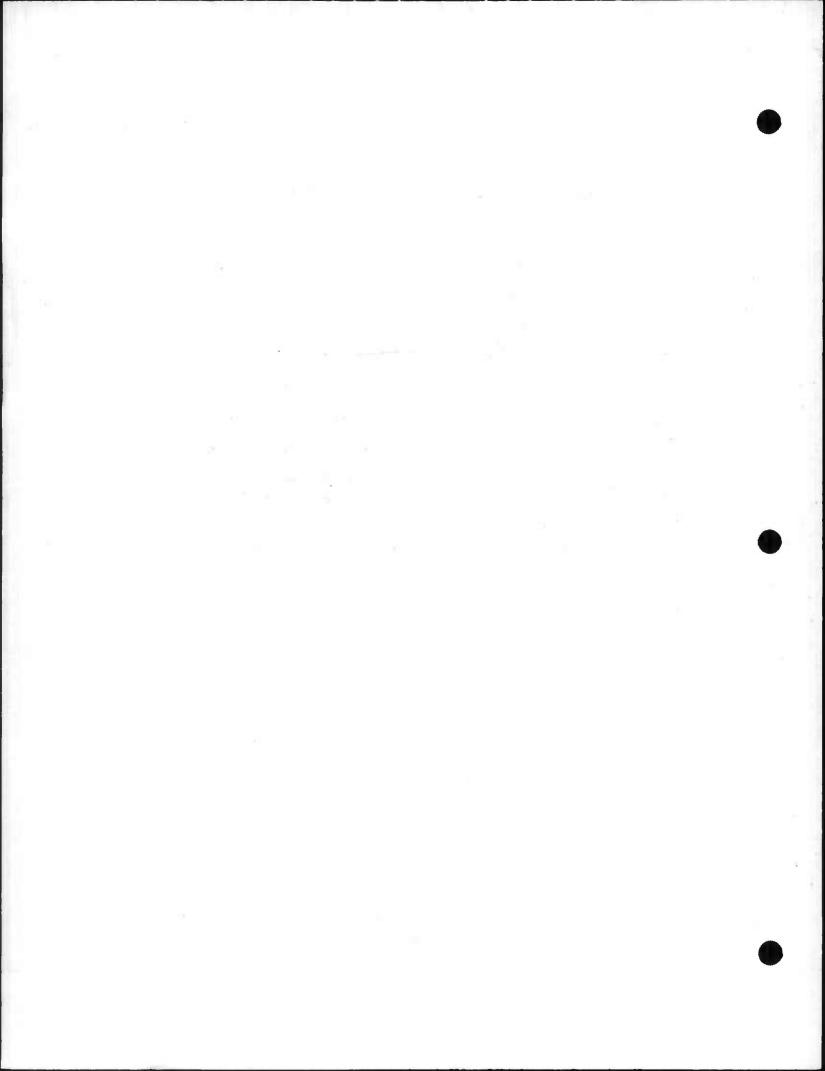
DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 19 95 N ABDUL WESBY -BEY JUNE 3:31 P.M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthdey) 7. DATE OF BIRTH APPRIED IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 216-90-2005 1X M 2 | F 19 DAYS HOURS VDC MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH N/A JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10a STATE 10b. COUNTY IOC. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD N/A BALTO 1 X YES 2 NO 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21218 2801 Kennedy Avenue USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 X Never Married 2 Married Specify:Black 3 Widowed 4 Divorced 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) N/A Elementary/Secondary (0-12) 11th grade Unployed Unemployed N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Salter Chrystal Wesby 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Walker 2801 Kennedy Avenue Baltimore, Md 21218 20a, METHOD OF DISPOSITION
1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State King Memorial Park 6249\$ Randallstown, 4 Donation 5 Other (Specify) Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore Md 21215 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feliure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition hounds of chast Shot Kun reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 | NO OF DEATH? TOYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO 1 ☐ Inpetlant 2 ☐ ER/Outpetlent 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 6-19-95 56 M 1 YES 2 NO Investigation 2 Accident 28a. PLACE OF INJURY -- At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number City or Town, State) 3 Sulcide 8 Could not be 4 Homicide Street 81 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steled. 2 😾 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as steted, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. JUNE 20,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Dey, Year)

JUN 2 3 1995 Julia daudion-Rardall



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	1 - STATE REGISTRAR	7			ICATE				MENTAL H	G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	6.	1100	LF					2. DATE OF D	EATN DA		YEAR	3. TIME OF OEATH P	
	4. SOCIAL SECURITY NUMBER 5	s. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BI	LACE (State or Foreign				
	218-28-5391	1 😡 M 2 🗆 F	63	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 16,1932 Mary					
	9s. FACILITY NAME (If not institution, give stree	et end number)	- 00		9b. CITY,	TOWN O	R LOCATI	ON OF D	EATH		9c. COUN	TY OF DE	ar vrano	
DIRECTOR	6148 Wooded Run Drive Columbia Howard													
IRE	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											10d, INSIDE CITY LIMITS?		
	Maryland Balt		Catonsville									1 YES 2 NO		
ERAL		IO. 2F CODE 10g. CITZEN OF V									ZEN OF WI	IAT COUNTRY?		
FUNE	407 Rockway Roa	2. WAS DECEDENT	EVER IN II 9 A	DMED	1 12 14		212		NC OBIONIS IS-	-14 M			ISA	
	1 Never Married 2 Married	FORCES? 1 [ IF YES, GIVE WA	XYES 2	NO	11	yes, spe	city Cubs	n, Mexice				- American Indian, White, etc.		
BY	3 Nidowed 4 Divorced	Korea			_   '	☐ TES	2 KNO	Specif	y:		- 1	Specify	hite	
0	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION	16a, Di	ECEDENT'S	USUAL OC	CUPATIO	N		16b. KIND	OF BUS	INESS/IND			
LET		College (1-4 or 5 +)	5964	Do NOT us	e retired.)	uning mos	IT OF WORKIN	Ø						
COMPL		+4		Eng	lish	Pr	ofe	SSO	r	Edu	cati	on		
00	17. FATHER'S NAME (First, Middle, Last)				58.5		18. MOTI	ER'S NA	ME (First, Middle,	Maiden	Sumame)			
B	Ernest Wolf								en Buc					
0	19e. INFORMANT'S NAME (Type/Print)		19						Route Number, Cit					
_	Roxanne Wolf							i Co	ourt G	len	Arn	Md.	. 21057	
	20a. METHOD OF DISPOSITION 1 Device 2 Comments 3 Remove	of from State	20b. PLACE cemetery, cre	maton, or o	thes africal						CATION —		*	
	4 Donation 5 Other (Specify)	-	Metr	O C	rema	tor	У	6,	/23/95	Ca	tons	svil	le,Maryla	
	The state of the s	7		0			LOSE		uneral	Ho	me. I	nc		
	1 de t	7 3		L.		132	8 St	ıl pl	nur Sp	rin	a Ro	had '	21227	
_	23. BART I. Enter the diseases, or con shock, or heart failure. Lia	npilications that	caused the de	eth. Do r	not enter t	the mod	le of dyl	ng, auc	h as cardiec o	r reapi	ratory arm	eat,	Approximata	
	IMMEDIATE CAUSE (Final		A STATE OF										Interval Between Onset and Death	
	disease or condition resulting in death)	Resp.	irn fin	4 4	viil	~(							1 week	
		DUE TO (	OR AS A CONSE	OUENCE O	F):									
Z	Sequentially list conditions 6.	Rena	Cen	Carc	rain	~ N	190	of li	tic to	10	15,6	cre	Cmarthe	
Ĕ	Sequentially list conditions, If any, leading to immediate Due to (OR AS A CONSEQUENCE OF):													
RTIFICATION	CAUSE (Disease or Injury	OUE TO /	22 42 4 2242											
E	that initiated events resulting in death) LAST	OUE 10 (0	OR AS A CONSE	OUENCE O	F):									
CER	d												-	
4	PART II. Other algnificant conditions of	contributing to d	leeth but not i	resulting	in the und	lerlying	ceuse g	lven in	Part I. 24s.	WAS AN	AUTOPSY		VERE AUTOPSY FINDINGS	
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ME	Proton/calmi	re malnu	sof jort	1. 0	~~~~	16	100	2:00			Acres		DF DEATH?	
	DID TOBACCO USE CONTRIB	BUTE TO CAL	JSE OF DEA	TH YE	S 🗆 N	10 🕱	UNC	ERTAIL	V					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check or									
SIC		OSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		S N Re	sidence	8 Other (Spec	iffy)				
H	27. MANNER OF DEATN	28e. DATE OF II		28b. TIM	E OF	28c. INJU	IRY AT		28d. DESCRIBE		JURY OCC	URED		
BY	1 Natural 5 Pending 2 Accident Investigation	M 1 YES 2 NO												
0	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, atreet, tectory, office building, etc. (Specify)						261. LOCATION City or Town	261. LOCATION (Street and Number or Rural Route Number,						
ETE	4 Homicide determined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						Oily or low	r, Stelley				
P	29e. CERTIFIER (Check only													
COMPL		one) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner es stated.												
15	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED													
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	30. NAME AND ADDRESS OF PERSON WHO C													
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urs after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should notified at 9 must medical examiner completely filled in by the rial, cremation, or removal. ö the cremation, event. to burial, traumatic and the attending physician Mental Hygiene prior to or other injury, ( of Health and N item 23 shows any has be Dept. L the State Charter 6 is marked, death with L DIRECTOR: A hours after d 28 IMPORTANT: If Item 8 FUNERAL I THE THE 뿚 2 2 3

FOR STATE REGISTRAR STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 06 6. AGE (In yrs. last pirthday DAYS 9c. COUNTY OF DEATH COMPLETED BY FUNERAL DIRECTOR RESIDENCE OF 10b. COUNTY IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY IMP 1 YES 2 | NO 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? d 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cyban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puarto

1 YES 2 NO Specify: 1 Never Married 2 Married YES, GIVE WAR OR DATES Widowed 4 Divorced 15. DECEDENT'S EDUCATION ecify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY e (1-4 or 5+) 2 0 17. FATHER'S NAME (First 18. MOTHER'S NAME (First, Middle BE 2 20b. PLACE AND DATE OF DISPOSITION (Na Burial 2 Cremation 3 Removal from State 5 Other (Specify) 22. NAME AND POPRESS OF FACILITY
JOSEPH LIKE
2222 W. NOTTH Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as about, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) rears DUE TO (OR AS A CONSEQUENCE OF): Dhan CERTIFICATION Sequentially list conditione, if any, leading to immediate DUE TO (OR AS A CONSEO cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. COMPLETED BY PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY 1 YES 2 1 - YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) EXAMINER? HOSPITAL 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED

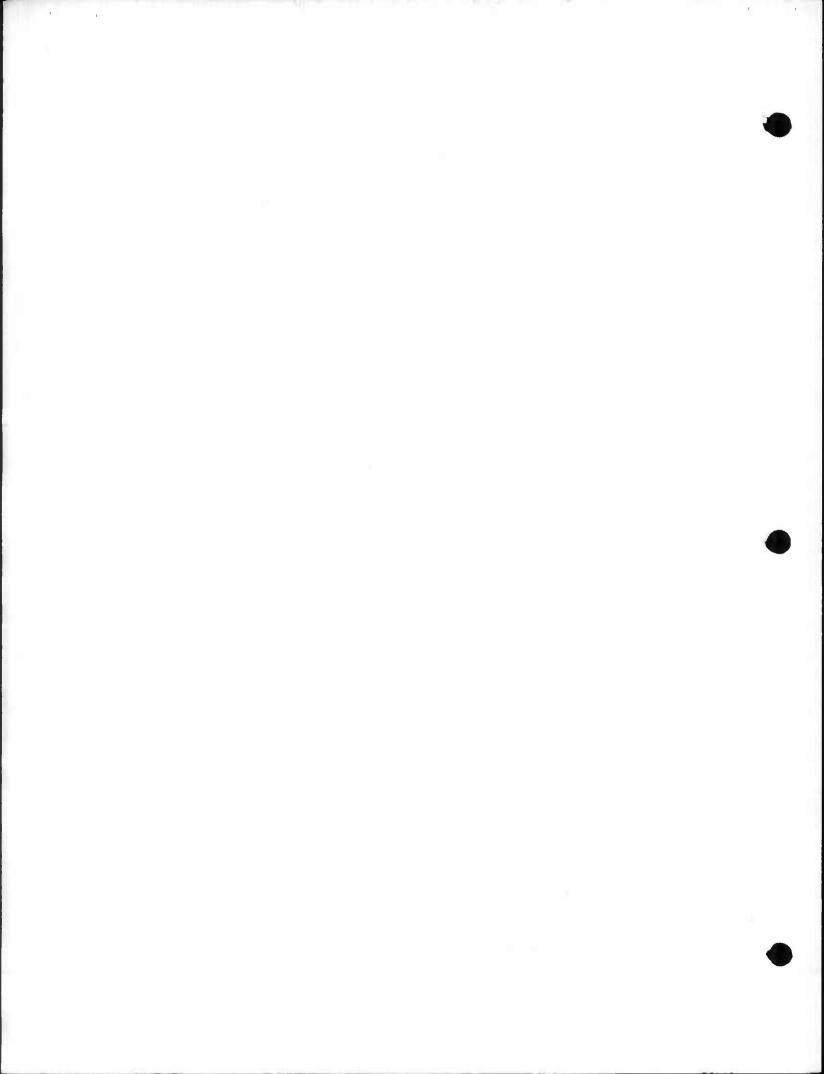
Accident	5 Pending Investigation	M 1 Tes 2 N	0
Sulcide Homicide	8 Could not be determined	28e. PLACE OF INJURY — At home, farm, etreet, factory, offica bufiding, etc. (Specify)	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)
CERTIFIER	<u> </u>		
Chack only	CERTIFYING PHYSICIAN	: To the best of my knowledge, death occurred at the time, data and place, an	d due to the councie) and manner as stated

2 MEDICAL EXAMINER: On the basis of exem

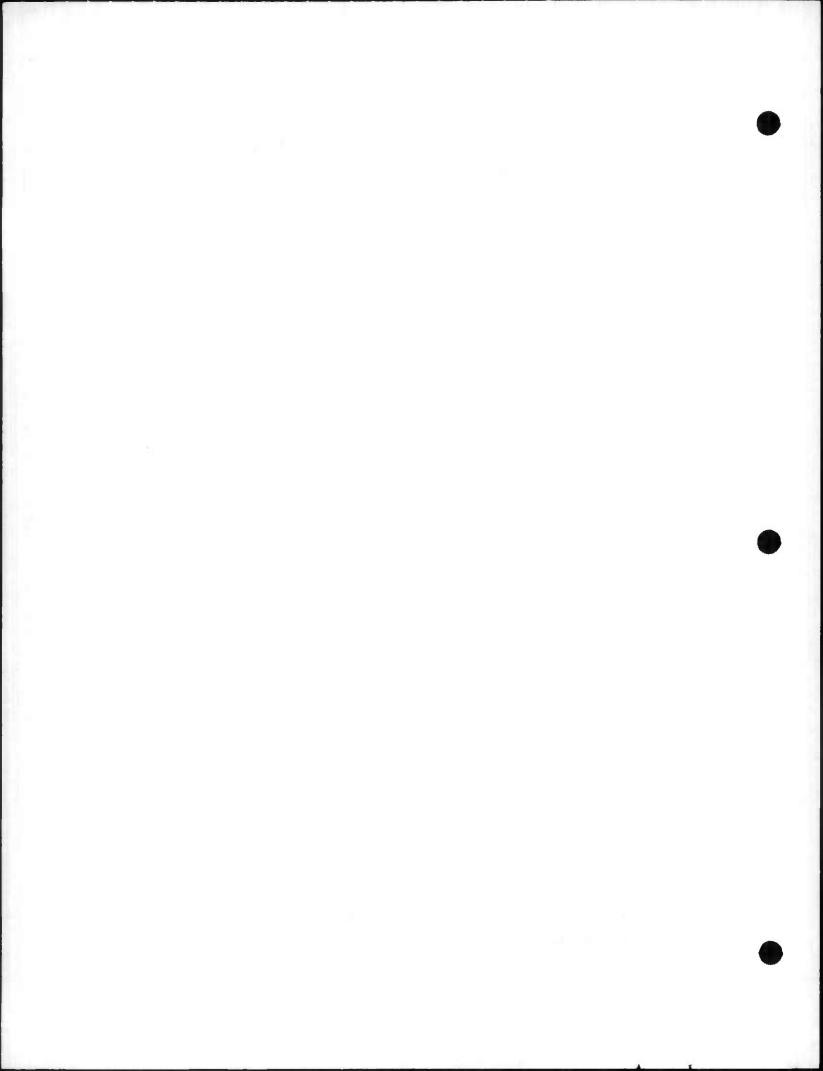
SIGNATURE AND TITLE OF CERTIFIER	293	LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

marie A Johns W	D29923	198694
NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	Dayl Olage B	-06 no 0 2120-

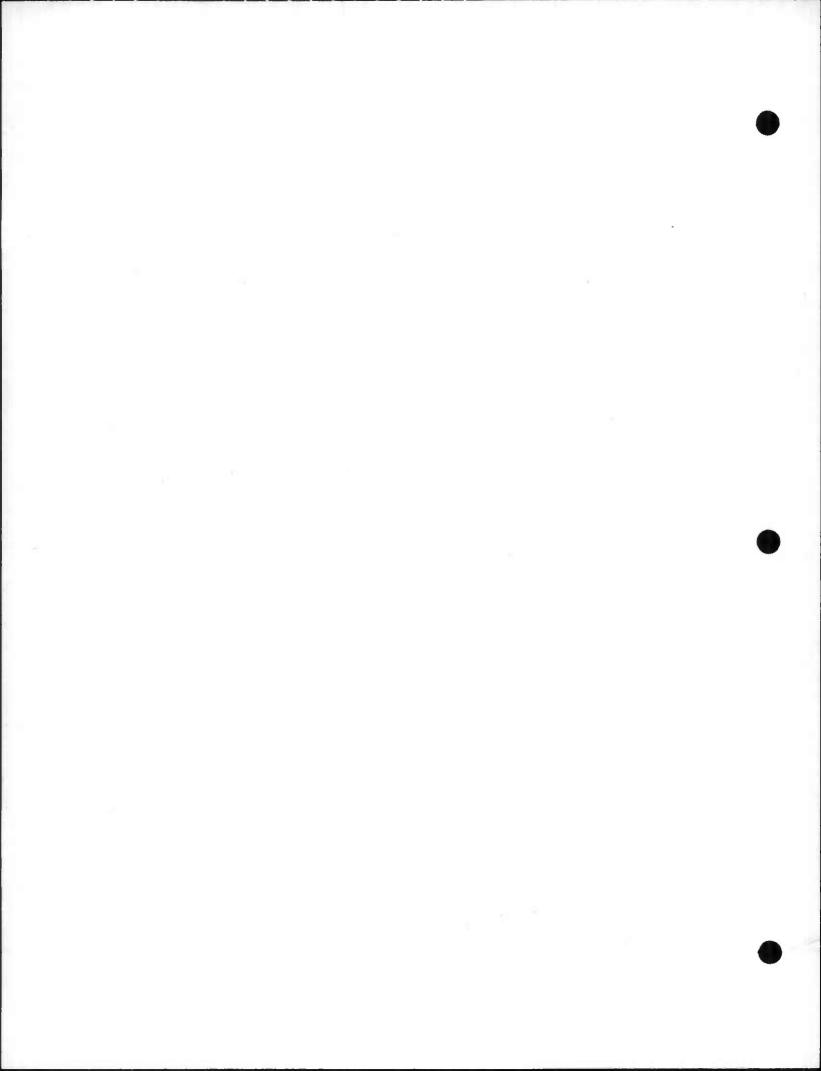
201 St. Pavi Place Daulo INICA 91909 JUN 2 3 1995 R REGISTRARY SIGNATURE



		1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF		MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)	torne	Ward	L		2. DATE OF DEATH		3. (5)	TIME OF DEATH
pin		4. SOCIAL SECURITY NUMBER 247.36.4941	1 □ M 2 □XF	(In yrs. lest birthdey)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-7-1928		Country)	ROLINA
. 2. 3 should	TOR		ANNE ARI							
it. Pages 1	DIRECTO	10a. STATE 10b. COUNTY	ARUNDEL		EN BURN					d. INSIDE CITY LIMITS?  YES 2 V NO
n. ansit permit.	VERAL	109 C STREET S.1	Ñ.			21061				T COUNTRY?
215-0020 attending physician. se as the burlal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 XXMerried 3 Widowed 4 Olvorced	12. WAS DECEOENT EVER FORCES? 1 YES	2 NO	If yes, a	CENOENT OF HISPA pecity Cuban, Mexic S 2 XNO Speci	INIC ORIGIN? (Specify an, Puerto Rican, etc.)		4. RACE — Black, W	American Indian
21 for u	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u		lost of working	16b. KIND OF 8	BUSINESS/INDUS	ITRY	
MARYLAND : retained by the hospital 5 should be detached it notified at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last) THOMAS HO	NONE DRNE	DIETAR	Y WORKER	18. MOTHER'S NA	AME (First, Middle, Maid	SING HO	ME	
MAR retained 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)  ROBERT E. WARD	JANE				Acute Number, City or 1			
BALTIMORE, er death. Page 6 may be the funeral director, page val.		20a. METHOD OF DISPOSITION  1 X Burlei 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	wal from State	b. PLACE AND DATE	of disposition (A other place) HILL CEM	leme of IETERY	DATE 20c.	LOCATION CIT	y or Town,	
BALTIN rs after death. Pag n by the funeral di removal.		· Janiny	1 Sie	tel	1 SE	COND AVE	SINGL S.W. GL	ETON FU EN BURN	TE N	L HOME MD. 21061
24 hours filled in b on, or rer		23. PART L Enter the diseases, or control of the co	lat only one cause on	each lina.	not enter the me	ode of dylng, auc	ch aa cardiec or res	ipiratory arres	ŧ,	Approximata Interval Between Onset and Death
687 ecuted and con burial.	NC	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE O						3 yrs
BOX ficate be physician ne prior t	CERTIFICATION	If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								
O 8 € ≥ €	AL CER	PART II. Other significent conditions	contributing to death	but not resulting	In the underlyin	ng cause given in	Part I. 24s. WAS	AN AUTOPSY	24b. WEI	RE AUTOPSY FINDINGS
w requires that the been signed by off. of Health and shows any in	MEDIC/						PERF	2 NO	COI OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
Z3 Per	SICIAN:	DID TOBACCO USE CONTR  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IBUTE TO CAUSE (		ES NO C		N			
OF PHYSICI this cer with th	PHY	27. MANNER OF OEATH  28e. DATE OF INJURY (Month, Day, Year)  28e. TIME OF INJURY AT WORK?  28d. DESCRIBE HOW INJURY OCCURED								
DIVISION OF OR ATTENDING PHYSI DIRECTOR: After this o hours after death with Item 28 is marked,	ETED BY	3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Steet)								Number,
7 70+	COMPLE		SICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as attated.  HER: On the beste of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.							
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	1 Cau	ich.	MI)	29c. LICENSE NU	17083	29d. DATE S	IGNED (Mor	nth, Day, Year)
5		218 N. Charles S	Street Suite	300 Bal		MD. 212	01			
		JUN 2 3 1995	Julia Deviles	x-Randall						

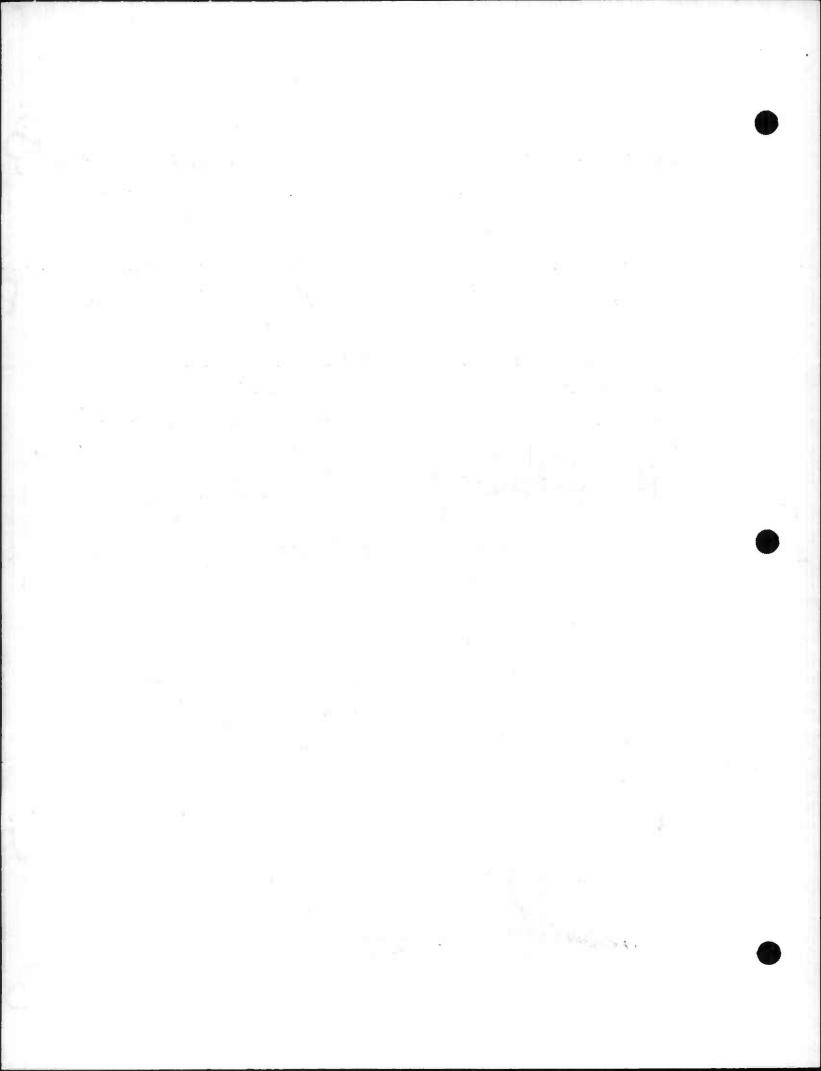


			1 - FOR STATE REGISTRAR	STATE OF MARYL			F HEALTH AND	MENTAL	HYGIEN REG. NO			
			t. DECEDENT'S NAME (First, Middle, Last)						OF DEATH	17.	3.	TIME OF DEATH
			Agnes Lee Weber					June		1995	PASY	10:00 A.
	D		4. SOCIAL SECURITY NUMBER 213-74-4276	5. SEX 6. AGE (	In yrs. lest birthday)	IF UNDER 1 YEA		7. DATE O	F BIRTH	1		ACE (State or Foreign
	should	~	9e. FACILITY NAME (If not institution, give si	reet end number)			VN OR LOCATION OF C	EATH		9c. COUNT	Y OF DEAT	ГН
	2.3	ECTOR	17 Willow Avenue			Over	lea			Balt	imor	e County
	Pages 1.	EC	IOa. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO	CATION				10	d. INSIDE CITY
	if. Pa	DIRI		more County	Ove	erlea					1	LIMITS?
	permit.	3AL	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZE	N OF WHA	AT COUNTRY?
ian.	transi	FUNERAL	17 Willow Avenue				21206			U.S.		
5-0020 nding physician.	the burial-transit	BY FU	1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes	DECENDENT OF HISPA , apocify Cuban, Mexic YES 2 1 NO Spec	en, Puerto Ri				American Indian, Thite, etc.
215-00 attending	use as the	ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S U		ATION most of working	16b.	KIND OF BU	SINESS/INDU		
§ 2	ğ	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)	i most or wonang					
ND 2	detached once.	COMPL	7th Grade		Homemake	er			own Ho			
YLA by the	at on		17. FATHER'S NAME (First, Middle, Last)  Lorenzo Dow Ford				18. MOTHER'S N					
	should t	BE	19e. INFORMANT'S NAME (Type/Print)		195 MAILING	DDDESS /SIM	Lottie  et end Number or Rurel					
<b>5</b> §	5 5	유	Donald Lee Weber				venue, Bai					206
RE, I	page of the		20e. METHOD OF DISPOSITION	20b.	PLACE AND DATE OF	FDISPOSITION	/Name of	DATE		CATION - CH		
0 2	director, p		Buriel 2 ☐ Cremation 3 ☐ Remote     Donation 5 ☐ Other (Specify)	Bi	altimore	Cemete	ery 6/2	24/95	Bal	Ltimor	e, Ma	aryland
ALTIMOR death. Page 6 ma	e funeral di I. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1	22. NAMI	C. Mille	ACILITY				
BAL er deat		W. 19	Kalblun	M. Muy	sky	6415	Belair Ro	pad. F	altin	ore.	Marv]	land 2120
rs after	d in by the or removal. medical e		23. PART/1. Enter the diseeses, or c	omplications that caused list only one ceuse on ea	the death. Do no	ot enter the	mode of dying, su	ch as cerdi	ec or reap	iratory arres	t,	Approximate
- 2	D & E		IMMEDIATE CAUSE (Finel	. /	4		1					Onset and Daar
4	ompletely fill I. cremation. event, the		disease or condition resulting in death)	. permu	CONSEQUENCE OF	16 a	wease					3 mmta
1760 ted wi	al. cr			A ( C I A )	CONSEQUENCE OF)	:						ors
executed	matic	ERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF)							7
e C	prior 1	CAT	if any, leading to immediate cause. Enter UNDERLYING									
O. F	piene ph	Ė	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)	:						
ı ∈	al Hyg	EB	resulting in death) LAST	J								
9	y the attend Mental	L C	PART II. Other aignificant condition	contributing to deeth be	ut not reculting in	the underly	ying cause given in	Part I.	24a, WAS AN		24b. WI	FRE AUTOPSY FINDINGS
that C	D 20 30	MEDICAL	<i>N</i>	DOM					PERFOR		CC	MILABLE PRIOR TO IMPLETION OF CAUSE
RECO requires th	een signed of Health a shows am	MEC										DEATH?
>	has been Dept. of n 23 sho		DID TOBACCO USE CONTE	RIBUTE TO CAUSE O	F DEATH YES	□ NO	UNCERTA	N 🗆				
A E	ate ha	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	Check only o	ne)					
CIAN	the Si	IYS I	1 VES 2 NO	1 Inpatient 2 ER/Outp	etient 3 DOA 4	4 - Nursing t	iome 5 Residence					
5 E	fter this c eath with marked,		Neturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b, TIME	RY	INJURY AT WORK?	28d. DESC	RIBE HOW I	NJURY OCCU	RED	
DING C	4 6 m	BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	At home, lerm, str			28f, LOCA	FION (Street o	end Number or	Rumi Brud	a Alumber
DR ATTENDING PHYSICIAN:	28 afte	9	4 Homicide 6 Could not be	building, etc. (Spec	H(y)			City of	Town, Stete)		11001	o riginizar <sub>q</sub>
- B	DIRE Hours	COMPLET	290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowl	ados death occurred	at the time of	tete and place, and du	to the cour	o(a) and man			
TO THE HOSPITAL	코 2 도	JMC		R: On the besis of examination								nd manner se stated,
HOS	TO THE FUNER be filed within 7 IMPORTANT:		296. SIGNATURE AND TITLE OF CERTIFIES	1			19c, LICENSE NU					onth, Day, Year)
王。	MP File	BE	10	M			DSZ	7+3				, 1995
-		2	30. NAME AND ADDRESS OF PERSON WHO			,		, , , , ,				
	χI		Dr. Alan Kimmel,	220 West Cold	Spring :	Lane,	Baltimore	, Mar	yland	21210	)	
			31. DJUN 2 3 1995	dinsolson Cord	<b>NO</b> E							
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	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF HE		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)	)				2. DATE OF DEATH	M MEA	3. TIME OF DEATH
	George					June 19	1995	9 A M
	4. SOCIAL SECURITY NUMBER	}	(in yrs. lest birthday)	7	F UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. Bil Co	RTHPLACE (State or Foreign untry)
	222-34-2683		15 YRS.			03/17/5	0 0	elaware
(C)	9e. FACILITY NAME (If not institution, give			9b. CITY, TOWN OR		ATH	9c. COUNTY O	
DIRECTOR	RESIDENCE OF DECEDENT	del Hospital		Glen B	urnie		Anne	Arundel
H H	10a. STATE 10b. COUNT	TY	10c. CIT	Y, TOWN OR LOCATION	V ·			10d. INSIDE CITY
		nne Arundel		Glen Bur				1 WES 2 X NO
FUNERAL	100. STREET AND NUMBER			10f. ZI	P CODE		10g. CITIZEN O	F WHAT COUNTRY?
N	11. MARITAL STATUS	ater Way Apt			21061		US	
	1 Never Merried 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO	If yee, specit	y Cuben, Mexicer	IC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	В	ACE — American Indian, lack, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	AIES	1 TYES 2	NO Specify		S	White
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	UCATION fe completed)	18e. DECEDENT'S	USUAL OCCUPATION work done during most of	of working	16b. KIND OF BUS	INESS/INDUSTR	Υ
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	e retired.)				
M	12 17. FATHER'S NAME (First, Middle, Last)	0	Sal	esman		Baker		
		+		7 7		ME (First, Middle, Meiden :	Surneme)	
BE	G. Lester Zot  190. INFORMANT'S NAME (Type/Print)		19b, MAJLING	ADDRESS (Street and		Cohee  Oute Number, City or Town	State 7in Code	
2	Thomas L. Zot	t	R.D			Lincoln		19960
	20er METHOD OF DISPOSITION  1 N Burial 2 Cremation 3 Rer	206	PLACE AND DATE O	F DISPOSITION / Name	of	7	CATION — City or	
	4 Donation 6 Other (See		Bloomer	y Cemete	ry	6/21 Fe	derals	burg, MD
	21. SIGNATURE OF FUNERAL DEPORTE	I A	_	Hardes	ADDRESS OF FAC	ral Home-2	no Laws	St
	Margaret.	Harry			ville,		OL LUW	
	23. PART I. Entar the diseases, or shock, or heart fallure	complications that cause. List only one cause on e	the deeth. Do n	ot enter the mode	of dying, such		ratory arrest,	Approximata
	IMMEDIATE CAUSE (Final							Interval Between Onset and Death
	disease or condition resulting in death)	acut	E Myor	cardial a	uforce to	24		
				7);				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF	7);				
\§	cause. Enter UNDERLYING	C.						
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	7:				
H	resulting in death) LAST	d						
AL C	PART II. Other algnificent condition	ns contributing to deeth b	ut not resulting i	n the underlying c	ause given in i	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
2						PERFORI		AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC								OF DEATH?
ż	DID TOBACCO USE CONT	TRIBUTE TO CAUSE O	F DEATH YE	S NO D	UNCERTAIN	<u></u>		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:	1.5			
YSI	1 TYES 2 NO	1 Inpatient 2 ER/Outp		4 - Nursing Home	100	8 Other (Specify)		
	27. MANNER OF CEATH  1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Yeer)	28b. TIMI	URY WORK	?	28d. DESCRIBE HOW IN	JURY OCCURED	
BY	2 Accident Investigation	28e. PLACE OF INJURY	- At home form o		2 NO	and a Control of		N
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spec	elfy)	treet, tectory, ornice		28f. LOCATION (Street et City or Town, State)	nd Number of Hur	al Houte Number,
<u>=</u>	200. CERTIFIER CERTIFYING PHYS	SICIAN: To the best of my know	ledge death occurre	d at the time, date an	d alone and due	-		
M.		IER: On the basis of examination						se(e) and manner se stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE				c. LICENSE NUM			IED (Month, Day, Year)
BE	Clust.	Carol			d. 349			19, 1995
유	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)			34110	,
	Dr. Alex J	erome 80	28 Ritch	ie Hwy. P	asadena	, Md. 2112	2	
	31. DATE FILED (Month, Day, 16ar)	3 1995 July	ATTORE	relath				
	6/19/4/14	0 330						



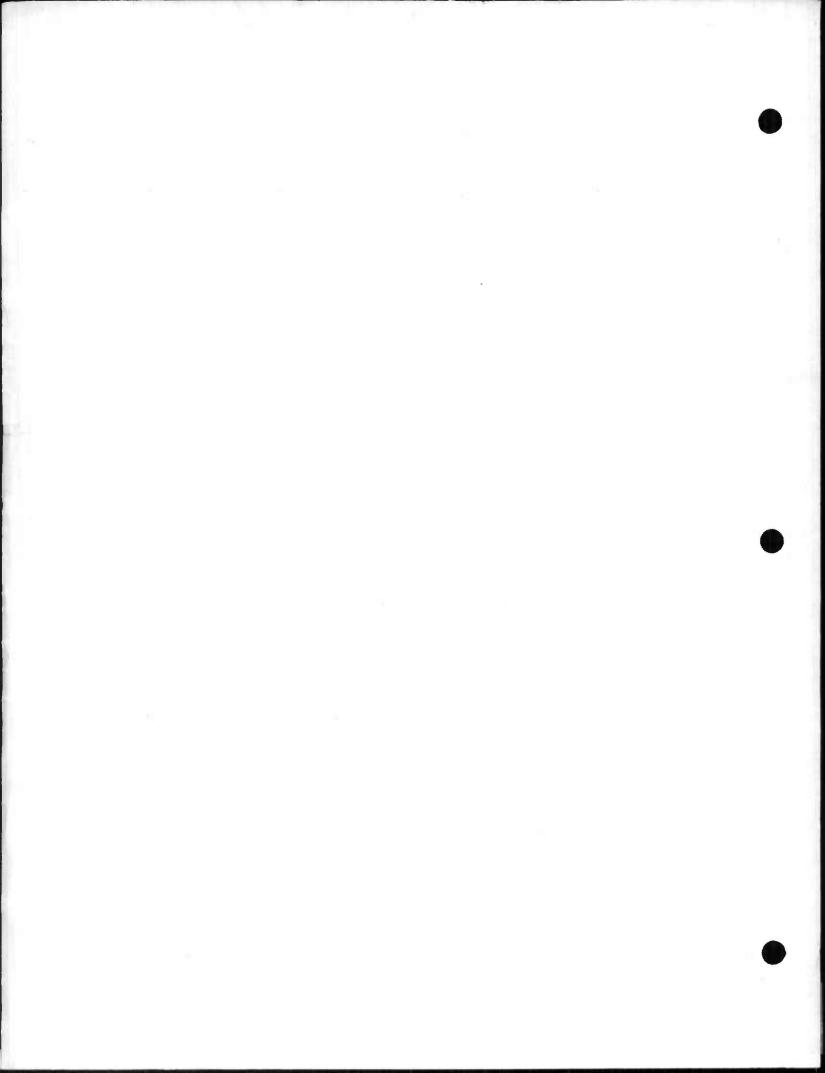
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALLIMONE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If tem 28 is marked, or liem 23 shows any injury or other traumatic event, the medical examiner must be notified at once.
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Frank A. Finner

31. DATE FILED (Morith. 10 1995)

AL REGISTRAR'S SIGNAPORE LIVE & RUSSIAN NOVOLL

	FOR	STATE OF MA	ARYLAND /	DEPART	MENT OF H	IFAITH AND	MENTAL	HYGIEN			10.	
	1 - STATE REGISTRAR				ATE OF		MERINE	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last,						2. DATE (	OF DEATH		YEAR	3. TIME OF	OEATH
	Gertrude Eleano	r Ayers						2, 1		TEAR	6:00	A N
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. le:		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	Day, Year)		8. BIRTN Countr	PLACE (State	or Foreign
	220-26-6299	1 🗆 M 2 🖵 F	78	YRS.	ONTHS DAYS	HOURS MIN.		25,	1916		yland	
	9a. FACILITY NAME (If not institution, give	street and number)		1	b. CITY, TOWN (	OR LOCATION OF D	EATH		9c. COUN	ITY OF D	EATH	
6	Kensington Gard	ens Nursir	ng Home		Ken	sington			Mon	tgon	nery	
<u>[</u> ]	RESIDENCE OF DECEDENT  10a. STATE  10b. COUN				TOWN OR LOCAT	TON .					44.4 01010.5	AITH
DIRECTOR											10d. INSIDE	
	100. STREET AND NUMBER	ntgomery		51.	Lver Sp	ZIP CODE			T son curre	TEN OF V	1 X YES :	
FUNERAL	911 Helena Drive				100	20901			2.5	U.S.		41.6
N.	11. MARITAL STATUS	12, WAS DECEDENT	EVED IN II S AS	DMED	12 WAS DEC	ENDENT OF NISPA	NIC OBIOIN	1 (Paralle, Wa				1.4
	1 Never Merried 2 Married	FORCES? 1 [	YES 2	NO	If yes, sp	ecity Cuban, Mexico	an, Puerto R		07 NO-		— American t, White, etc.	Indian,
ВУ	3 ☑ Widowed 4 ☐ Divorced	IF YES, GIVE WA	H OH DATES		1 U YES	2 XNO Specif	fy:			Speci	»: lite	
8	15. DECEDENT'S ED	UCATION	16a. Di	ECEDENT'S U	SUAL OCCUPATION	ON	16b.	KIND OF BU	SINESS/IND			
E	(Specify only highest grace Elementary/Secondary (0-12)	College (1-4 or 5+)	IMe	Sive kind of wo Do NOT use	rk done during ma retired.)	st of working						
AP I	9		Но	memake	er			Own H	ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA	AME (First, M	iddle, Maiden	Sumeme)			
BE (	S. Mason Miller	·				Margar	et El	len B	arnes			
10 E	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING A	DDRESS (Street a	nd Number or Rural	Route Numb	er, City or Tow	n, Stete, Zip	Code)		
-	John Douglas Aye	rs, Sr.	9	ll Hel	lena Dr	ive Sil	ver S	pring	,Mary	land	2090	1
	20a, METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Res	moval from State	20b. PLACE	AND DATE OF	OISPOSITION (Na	me of	DATE	20c. LO	CATION —	City or To	wn, State	
	4 Donation 5 Other (Specify)		Parkl	awn Ce	emetery		/6/95	Roc	kvill	e Ma	rylan	d
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE			Eranc	is J. Co	ACILITY					
	1 (1) TU	221	01.			niversit				-		0901
	23. PART I. Enter the diseases, or	complications that	caused the de	eath. Do no	t enter the mo	de of dying, suc	ch as cerd	ac or resp	ratory em	oat.		ximata
	ahock, or heart fallure	. List only one caus	e on each line	0.		2			,	,	Interv	el Between
	IMMEDIATE CAUSE (Finel disease or condition	Cerebra	1 Vacc	ular /	Acciden	t						Hrs.
	resulting in death)	(II)	OR AS A CONSE								24	nrs.
2		Arterio	sclero	sis -	Genera	1					20	Yrs.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (C	R AS A CONSE	OUENCE OF):							+++	
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	Chronic	Obstr	uctive	e Pulmo	nary Dis	ease				15	Yrs.
띮	that initiated events	OUE TO (C	R AS A CONSE	OUENCE OF):								
臣	resulting in death) LAST	d										
	PART II. Other algnificant condition	na contributing to d	eeth but not	resulting in	the underlying	n cause given in	Part I	24a, WAS AN	ALITOPRY	246	WERE AUTOP	ev EINOINGE
EDICAL				9				PERFO	RMED?		AVAILABLE P	OT ROIF
							—	1 TYES 2	₩ NO		OF DEATH?	
PHYSICIAN: M	DID TOBACCO USE CON	EDIDLITE TO CAL	CE OF DEA	TU VEC	ENOF	LINICEDTAL					1 TYES 2	NO D
AN	25. WAS CASE REFERRED TO MEDICAL	I KIBUTE TO CAU			(Check only one)	UNCERTAI	иПТ					
를 등	EXAMINER?  1 YES 2 (2) NO	HOSPITAL:		(	OTHER:							
¥	27. MANNER OF DEATH	1   Inpetient 2   1		28b. TIME		e 5 🗆 Residence	7	(Specify) CRIBE HOW I	N HIRV OCC	YIDED		
	1 Natural 5 Pending	(Month, Day		INJU	TY WO	PRK7	28u. DEŞ	CRIBE HOW	NJUNY OCC	UNED		
Β¥	2 Accident Investigation 3 Suicide Could not be	28e, PLACE OF	INJURY - At he	ome farm str	eet, fectory, offic		20/ 1.004	TION (Street	and Mumber	or Dumi F	Route Number,	
COMPLETED	4 Homicide e Could not be	building, et	c. (Specify)		, 100101,, 01110	•	City o	r Town, State)	and reamber	Dr Hurer F	todie Number,	
<u> </u>	29a. CERTIFIER									_		
₩		SICIAN: To the best of m										
8		IER: On the basis of exe		veatigation,	m my opinion, d			una piece, ar				
BE	296. SIGNATURE AND TITLE OF CERTIFI	ER	7	. 0		29c. LICENSE NU			29d. DATE	SIGNEO	(Month, Day,	Mar)
10	20 NAME AND ADDRESS OF OFFICE	- gru	rug	<u> </u>		1350	47		6	5 -V	-91	
-	30. NAME AND ADDRESS OF PERSON W Frank A. Finner					.NW, Was	hinas	on T	C 20	0016	-4300	
li	rrank A. rrimei	Ly, JI. M	· D · 45	TO Ha	ss. Ave	· NW, Was	minge	UII, L	U 20	AUTO.	4700	



			577-52-3537	1 🔀 M 2 🗌 F	75	YRS.	MONTHS	DAYS	HOURS		lav 2		920	Ken	tucky
	3 should		Se. FACILITY NAME (If not institution, give	street and number)			9b. CITY, T	OWN OR	LOCATIO	N OF DEATH	u, 2	.0, 1		NTY OF OR	
	~	СТОВ	Suburban Hospital				Bet	hesd	la				Mon	tgome	ery County
	Jes 1.	Di l	10a. STATE 10b. COUNT	γ		10c. CITY	, TOWN OR	LOCATIO	ON .			_			10d. INSIDE CITY
	permit. Pages 1.	DIRE		omery Cour	ity	Bet	nesda								LIMITS?
	bed 1	₹	10e. STREET AND NUMBER						ZIP CODE				10g. CITI	ZEN OF W	HAT COUNTRY?
11	ransi	FUNERAL	6008 Avon Drive						20814		4			ted S	States
5-0020	se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT E FORCES? 1 X IF YES, GIVE WAR	VER IN U.S. AR YES 2 1 OR DATES	NO	If y	res, speci	NOENT OF Ify Cuban, X NO	HISPANIC O Mexican, Pu Specify:	RIGIN? (S erto Ricar	pecify Yea i, etc.)	or No—	14. RACE Black Specifi	- American Indian, White, etc.
215	USe as	9	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	CEDENT'S	JSUAL OCC	UPATION	-4 -41-		16b. KIN	D OF BUS	INESS/IND	USTRY	WIIICC
27	5 _	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT us	retired.)	my most	or working						
AND	detached once.	M P		66	Fin	ancia	al Ma	nage	er		Неа	1th	Indu	stry	
A	detach once.	8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAME (	First, Middl	e, Maiden	Sumame)		
NY I	id be	BE	Mark Holland Alle	n						Gree					
MARYLAND	5 should notified	0	19a, INFORMANT'S NAME (Type/Print)							r Rural Route				Code)	
	3 8 9		Francoise Puvis-A	llen						ethes	da,	т.		208	
IMORE	ector, p		20a. METHOD OF DISPOSITION . 1 X Burlal 2 Cremation 3 Rem	oval from State	20b. PLACE / cemetery, cre						DATE		CATION —		
M	direc		4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LI	CENCEE A	Fort	Linco						Bre	ntwo	od, M	laryland
BALTIMORE,	the funeral director, wal.		· Mark	1 Vec	900		For	t Li	ncol	n Fun	eral		-		MD 20722
111	£ 5 €		23. PART I. Enter the diseases, or	complications that co	eused the da	ath. Do n	ot antar th	a moda	of dyin	g, such aa	cardiac	or reapi	atory am	eat,	Approximate
	filled in on, or r		ahock, or heart failure.  IMMEDIATE CAUSE (Final	tier only one causa	on each line	l.									Interval Betwee
0	> 6 =	i	disease or condition resulting in death)	. 1	ut-a	6	De S	mo	man	~	55	Der	-47		mino
99	completely ial. cremati event, ti	1		DUE TO (OF	AS A CONSE	DUENCE OF	):					~			
68760	in and com to burial. umatic ev	Z	Composticity, list conditions	a out	ومناه	501.	ens	ru	-	theor	T	D	الإحور	2 2	4000
XO	ian a	Ĕ	Sequantially list conditions, if any, leading to immediate	DUE TO (OF	AS A CONSEC	DUENCE OF	):								
B	attending physician and c ntal Hygiene prior to buris y, or other traumatic	CERTIFICATION	CAUSE (Disease or Injury	C											
O. B(	he attending ph Mental Hygiene Ijury, or other	Ē	that initiated events resulting in death) LAST	DUE 10 (OH	AS A CONSEC	JUENCE OF	1:								
G. #		Ü		d		-									1
DS	ed by the att th and Menta any Injury,	A I	PART ii. Other aignificant condition	na contributing to da	ath but not r	eaulting is	tha unda	rlying o	cause giv	ven in Part	l. 24e	WAS AN			WERE AUTOPSY FINDIN
CORD	signed by the Health and lows any ln	DICAL									1.5	YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?
Ш	een sign of Heal	ME													1 YES 2 NO
L R			DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEA	TH YE	S   NO	D 🗆	UNCE	RTAIN [	וכ				
VITAL AN: The law	icate has State Dep item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT		y one)							
	20 2		1 YES 2 NO	1   Inpatient 2   EF	VOutpatient 3	□ DOA	OTHER: 4 - Nursin	g Home	5 🗆 Resi	dence 6 🗆	Other (Sp	ecify)			
OF	this certificate h with the State [ brked, or item	PHY	27. MANNER OF OEATH  1 Natural 5 Pending	28a. DATE OF INJ (Month, Day, 1		28b. TIME INJU		Bc. INJUR WORK		28d	. DESCRIE	E HOW IN	JURY OCC	URED	
Z	t: After this c r death with Is marked,	B	2 Accident Investigation						S 2 🗌	NO					
DIVISION OF	DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 8 Could not be detarmined	28a. PLACE OF IN building, atc.	IJURY — At ho (Specify)	me, larm, si	reel, lactory	, offica		201.	City or To		nd Number	or Rural Ro	oute Number,
0 8			29a. CERTIFIER (Check only 1 CERTIFYING PHYS	CIAN: To the best of my	knowledge, da	ath occurre	at the lime	, data en	d placa, a	nd dua lo th	e causefai	and man	ner an state	ut	
ATIA	FUNERAL within 72 TANT: If	COMPL	one) 2 MEDICAL EXAMINE												and menner as stated
ME HOSPITAL	TO THE FUNERAL be filed within 72 IMPORTANT: If	Ü	29b. SIGNATURE AND TITLE OF CERTIFIE							SE NUMBER					Month, Day, Year)
1	De filed	<b>6</b>	De C	- Sandara C	Now	0		3	00	27	46	.	<b>&gt;</b> >	A A	workin, buy, reall)
=	= 6 =	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	F DEATH (ITER	4 27) (Type,	Print)				-		N	3	- CX -
	15		John	Tau ber	- 8	32	18	احما	900	w 9 1	~	AU	e.	3	atrial
			JUN 02 1995	132. REGISTRAR'S	SIGNATURE									-	0
	- 1	- 1	JUN 02 1995	Julya an imministration	rostall										

5. SEX

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

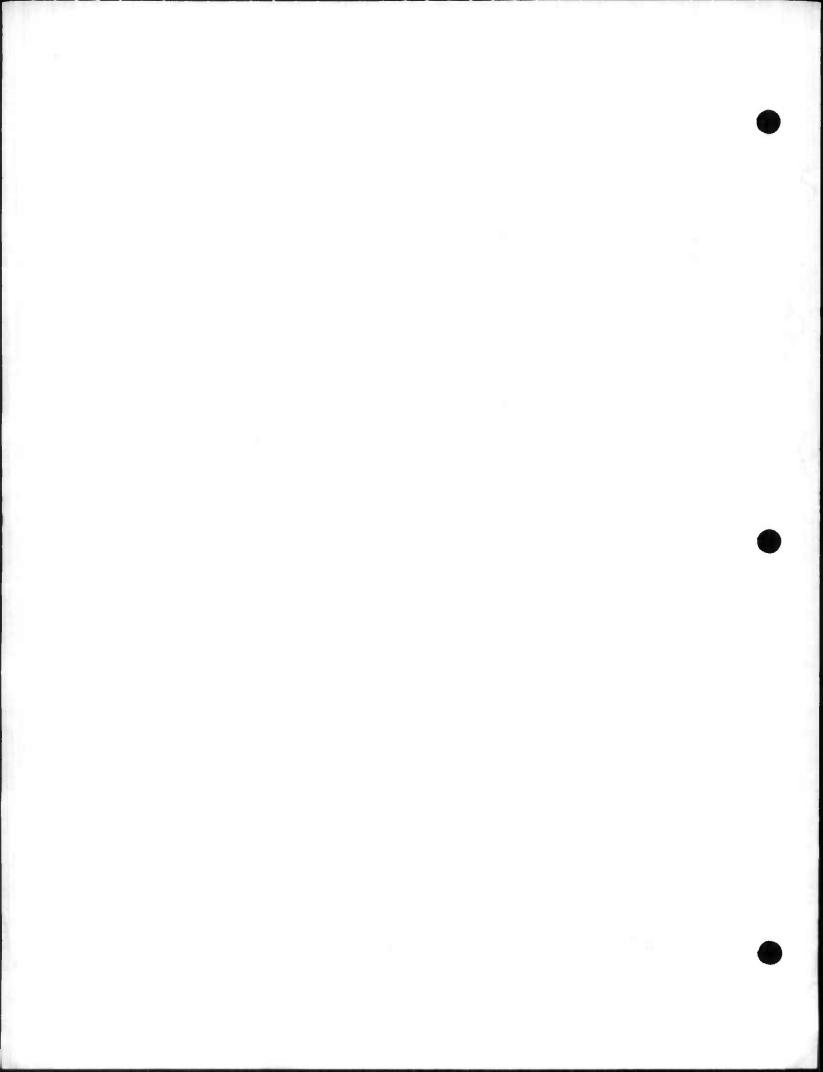
WILLIAM

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF OEATH 3. TIME OF OEATH 1995 MAY 1202 A" 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) BIRTHPLACE (State or Foreign Country) May 20, 1920 Kentucky ON OF DEATH 9c. COUNTY OF OEATH Montgomery County 10d. INSIDE CITY 1 TYES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? 4 United States OF HISPANIC ORIGIN? (Specify Yea or No— in, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whita, etc. Specify: Specify: White 16b. KIND OF BUSINESS/INDUSTRY Health Industry HER'S NAME (First, Middle, Maiden Surname) a Greenlee or Rural Route Number, City or Town, State, Zip Code) Bethesda, Maryland 20814 20c. LOCATION - City or Town, State DATE 6/3/95 Brentwood, Maryland ess of FACILITY nsburg Rd., Brentwood, MD 20722 ing, such as cardiac or respiratory arrest, Approximate Interval Between **Onset and Death** weres. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE given in Part I. 1 TES 2 NO 1 YES 2 NO ERTAIN sidence 6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

DIVISION OF VITA! BECORDE BO

BALLIMURE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 88760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARY	LAND / DEPARTA	MENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	YOUTHA B. ARCHIE			May 24, 1995	10:10 A. M
	A STATE OF THE PROPERTY OF THE		UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign
		9 YRS.	NTHE DAYS HOURS MIN.	Oct. 27, 1905	Country) Virginia
	9a. FACILITY NAME (If not institution, give street and number)	90	CITY, TOWN OR LOCATION OF DE		UNTY OF DEATH
DIRECTOR	Holy Cross Hospital		Silver Spring	Mon	tgomery County
Ĕ	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION		10d. INSIDE CITY
	Maryland Montgomery Count	y Sil	ver Spring		LIMITS?
AL	10e. STREET AND NUMBER		10f. ZIP CODE	10g. Cri	TIZEN OF WHAT COUNTRY?
FUNERAL	12001 Old Columbia Pike		20904	Un	ited States
준	11. MARITAL STATUS  1 Never Married 2 Married  12. WAS DECEDENT EVER FORCES? 1 YE		13. WAS DECENDENT OF NISPAN If yes, specify Cuban, Mexica	IC ORIGIN? (Specify Yes or No-	14. RACE — American Indian, Black, White, etc.
A	3 ∑ Widowed 4 □ Divorced IF YES, GIVE WAR OR		1 TES 2 NO Specify		Specify:
	15. DECEDENT'S EDUCATION	18a. DECEDENT'S USI	JAL OCCUPATION	16b. KIND OF BUSINESS/IN	Black
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)		done during most of working	TOO. KIND OF BOOMESO/III	DOSTAT
린	12	Elevator	Operator	Federal Go	vernment
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Malden Surname)	
BE	Earnest Anderson		Hessie	McKaney	
ē	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural F	loute Number, City or Town, State, Zi	(p Code)
-	Loretta Townsley	12001 (	old Columbia Pi	ke, Silver Spr	ing, MD 20904
	20a. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Removal from State	Ob. PLACE AND DATE OF Demetary, cremetory or other	ISPOSITION (Name of place)	DATE 20c. LOCATION	- City or Town, State
	4 Donation 5 Other (Specify)	ort Lincol	n Cemetery 5/3	80/95   Brentwoo	od, Maryland
- 1	· Villian	(	Fort Lincoln I	uneral Home,	Inc.
	Jesa S. Mail		3401 Bladensbu	rg Rd., Brenty	wood, MD 20722
1	23. PART I. Enter the diseases, or complications that ceus ahock, or heert fallure. List only one cause on	ed the death. Do not each line.	enter the mode of dying, sucl	as cerdiac or respiratory ar	rrest, Approximata intervai Between
	IMMEDIATE CAUSE (Final disease or condition	0.1101	1 -		Onset and Dasth
ı	disease or condition resulting in death)  s	Ja Puller a	Ceidelt		5 Days
_	- atmos	R CONSEQUENCE OF):	o cooling of		20 Years
Ó	Sequentially list conditions, if any, leading to immediate	A CONSEQUENCE OF):	e ce ce ce so		20 16415
3	CAUSE (Disease or injury	ed age			
E	that initiated eventa DUE TO (OR AS	A CONSEQUENCE OF):			
CERTIFICATION	resulting in death) LAST				
_	PART II. Other algnificant conditions contributing to death	but not resulting in the	he underlying ceuse given in	Part I. 24s. WAS AN AUTOPSY	245. WERE AUTOPSY FINDINGS
গ্ৰ	Musertersion, history of a	orthic steri	USII, Ferrend	PERFORMED3	AMILABLE PRIOR TO COMPLETION OF CAUSE
의	serticemia		773	1 TYES 2 MO	OF DEATH?
-	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO □ UNCERTAIN	<u></u>	1 YES 2 NO
동	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (	Check only one)		
Š	1 YES 2 NO HOSPITAL: 1 Supplient 2 ER/Ou		THER:  ☐ Nursing Nome 5 ☐ Residence	8 Other (Specify)	
PHYSICIAN: MEDIC	27. MANNER OF DEATN  28a. DATE OF INJURY (Month, Day, Year)		28c, INJURY AT WORK?	28d. DESCRIBE NOW INJURY OC	CURED
à	1 Natural 5 Pending 2 Accident Investigation		M 1 YES 2 NO		
	3 Suicide 6 Could not be 4 Nomicide determined	RY — At home, ferm, stree ec/fy)	t, factory, office	28f. LOCATION (Street and Number City or Town, State)	r or Rural Route Number,
ш	29a. CERTIFIER				
OMPLETED	(Check only 1 CENTIFYING PHYSICIAN: To the best of my kno				
္ပ	2 MEDICAL EXAMINER: On the besis of examinat	ion and/or investigation, in	my opinion, death occured at the	lime, data and place, and dua to ti	he cause(a) and manner as stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER		29c, LICENSE NUM	BER 29d. DAT	TE SIGNED (Month, Day, Year)
ဍ	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	EATH STEM OF CO.	1)39 19	/	129173
	LYNNE V. DERNY MAIN			210 511 150 61	On Lexible 20012
	31. DATE FILED (Month, Dey, Year) 32, REGISTRAR'S 290	NATURE	SUILLE KU H	210 21 CM-16 11	PMNGM020910
	JUN 02 1995 July davidson has	really			
	AA11 1000 ()				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1	STATE REGISTRAR		STATE OF I	MAKYL					DEAT		MENT	AL HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First,	, Middle, Last)					TOP-		D			E OF DEATH			3. TIME OF DEATH
			MARY	V.		LVEY						JU		, 19	95	7:30PM M
		4. SOCIAL SECURITY NUMBER 577-32-0545		5. SEX		(In yrs. lest		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DAT	E OF BIRTH		S. BIRTI	NPLACE (State or Foreign
	-			1 🗆 M 2 💢 F	9	1	YRS.						7,19			ÿland
oc.		90. FACILITY NAME (II not in Prince Geor									ON OF DE	ATN			NTY OF C	
유	F	RESIDENCE OF DEC	_	DSPICAL				Cil	ever	тĀ				Pri	nce	George's
DIRECTOR		10e. STATE	10b. COUNTY	*				Y, TOWN								10d. INSIDE CITY
	- 10-	Maryland	Prince	e George	s		U	pper	Mar	lbor	0					1 TES 2 NO
78		10e. STREET AND NUMBER	2 4. a.1a.2 a.	M11	- D				101	ZIP COD				_		WHAT COUNTRY?
FUNERAL	-	2 / U.L. K.I	rtcnie-	-Marlboro							0772				U.S.	
	- 11	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES	2 <b>X</b> N	NED		If yes, sp	ecity Cube	n, Mexican	n, Puerti	ilN? (Specify Yea o Ricen, etc.)	or No —	14. RACI	E — American Indian, ik, White, etc.
B	FR	3 🕅 Widowed 4 🗌 Divo	rced	IF YES, GIVE V	MCH OH D	DATES			1   YES	2X NO	Specify:			1	Spec	casian
		15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)		18a. DEC	CEDENT'S	USUAL O	CCUPATIO	ON st of working			86. KIND OF BUS		DUSTRY	
		Elementary/Secondary (0		College (1-4 or 5	+)	Me.	Do NOT us	se retired.)			79					County
COMPLETE	ŀ	8th 17. FATHER'S NAME (First, MI	Metallia ( = a)	N/A		Mana	ager	-Car	eter				School		em	
E 8	- 11	Harry	rodre, Lest)	Bro	own					18. MOTI	Mae	WE (First	, Middle, Maiden		ting	c
must be notified at once.  TO BE COM		19a. INFORMANT'S NAME (7)	ype/Print)	DIC	7411	19b	MAILING	ADDRES	S (Street a	nd Number	or Burn! D	loute Nu	mber, City or Town	- Carry 71:	0.41	
10		Mary V. E	3arnhai	ct		1	2703	Rite	chie	Mar	lboro	o Ro	d. Uppe	r Ma	rlbo	ro Md
2	Г	20a, METHOD OF DISPOSITI 1 X Buriel 2 □ Crematio	ION 3 Party	oursi from State	201	b. PLACE A	ND DATE	OF DISPOS	SITION /Na	me of T-	7	1 5 DA	TE 20c. LO	CATION -	City or To	own, State
Ē		4 Donation 5 Other	(Specify)			Resui	rrec	clon	Cem	eter	y 10	205	CI			aryland
examiner	ľ	21. SIONATURE OF FUNERAL											e Fune			•
		Charle	NX.	Bela	nge			6	633 (	OId 1	Alexa	andı	cia Fer 	ry R	D Cl	inton, Md
medical		23. PART I. Enter the di	iseasea, or c	complications the	t cause	d the dea	ath. Do r	not enter	the mo	de of dy	ing, such	aa ca	rdiec or respi	ratory an	rest,	Approximate
		IMMEDIATE CAUSE (Fin			/	/	1	1.	/		^		1			Onset and Death
E I		resulting in death)	<b>→</b> ,	1. CP1	CD	141		1150	1/1/	R	1/00	10	pal			141005
event,				DUE TO	(OR AS A	A CONSEO	UENCE O	F):		,						, , , ,
CERTIFICATION		Sequentially list conditi		DUE TO	(OR AS /	A CONSEO	UENCE O	F):								
S E	- 11	cause. Enter UNDERLYI	ING													į
TIFIC	1	CAUSE (Disease or injusthat initiated events		DUE TO	(OR AS	A CONSEC	UENCE OF	F):								
P H		resulting in death) LAS'	, f	d												
CAL CE		PART II. Other significa	nt condition	s contributing to	death t	out not re	paulting	In the ur	ndariying	cause ç	given in F	Part I.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS
을 길		13501	VIIC	1 1/	1104	1600	4/6	1575					PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
: MED						/	/ '						,			OF DEATH?
AN: 1		DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE C	F DEAT	H YE	S 🗆 I	NO D	UNC	ERTAIN					
PHYSICIAN: M	2	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HØSPITAL:		28. PLACE	OF DEAT	OTHER	_							
YS		1 TES 2 NO		1 2 Inpatient 2		patient 3 [		4 🗆 Nur	sing Home			_	ver (Specify)			
	I.	27. MANNER OF DEATN  1 Natural 5   1	Pending	28a. DATE OF (Month, D			28b. TIM	E OF URY	28c. INJU	RK?		28d. DI	EŞCRIBE HOW II	JURY OC	CURED	
B ¥		2 Accident	Investigation	28e. PLACE O	F INJURY	Y — At hor	ne farm	tract fact		'ES 2 [	-	204 1.0	CATION (Press)	and Alexandre	as Donat I	D
TED			Could not be determined	building,	etc. (Spec	cify)	re, rentin, a	erret, teci	ory, orne	'			CATION (Street a y or Town, State)	na Number	OF HUNEL F	10UTO NUMBER,
	2	29a. CERTIFIED	IFYINO PHYSIC	CIAN: To the best of	my know	viados das	th occurs	ad at the t	lma deta	and place	and due is				100	
MPURIANI: IT ITEM 2																a) and manner as stated.
E CO	2		OF CENTIFIER	<u>/_</u>							NSE NUMI					(Month, Day, Year)
8 8	L	WH /	1 dels	MMCH	91					1)/	475	4		1/	2/11	luc
5	P	MAME AND ADDRESS OF	PERSON WHO	OMPLETED CAUS	SE OF DE	ATH (TEM	27) (Туре,	Print)		V		_/_		0	711	1013
	L	Homas 1	17. C	X9US/NO	22	MO	75	25	6	1000	WAG	46	R Dr.	616	901	MAN
	j	JUN 1		32. REGISTRA	R'S SIGN	ATURE					7					20220
	L	20MI	9 1333	Jalia d	Much	works	rdall									,0

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with a first heart of the completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	L.R.B.										QL	5 1	8939
	FOR 1 - STATE REGISTRAR		STATE OF MA	RYLAND	DEPAR	RTMEN	T OF H	EALTH AND	MENTA	L HYGIEN		, ,	0 ) 0 )
	1. DECEDENT'S NAME (First, A	fiddle, Last)				IOAII	- 01	DEATH	2. DATE	OF DEATH			. TIME OF DEATH
	WILLIAM		KETTH			ית ע	KINS	2	JU	TH DA		YEAR	3:00A M
	4. SOCIAL SECURITY NUMBER	R		AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER 24 HRS.	7 DATE	OF BURTH			ACE (State or Foreign
	220 - 88 - 0		1 💢 M 2 🗆 F	23	YRS.	MONTHS	DAYS	HOURS MIN.	Jan	29, 19	972	Mary	land
DIRECTOR	90. FACILITY NAME (If not instituted in the control of the control							MORE CI			9c. COU	NTY OF DEA	TH
5	RESIDENCE OF DECE												
2		Ob. COUNTY				Y, TOWN	OR LOCAT	TON				1	Od. INSIDE CITY LIMITS?
ā	4	Howar	:d		La	urel						1	YES 2 1 NO
¥	10e. STREET AND NUMBER						100	. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
띨	9180 Old Sca	aggsvi	lle Road					20723			US	SA.	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDENT E					ENDENT OF HISPA			or No-	14. RACE -	- American Indian,
BYF	1 Never Married 2 M		FORCES? 1		NO		If yes, spi	2 XXNO Specific		Rican, etc.)		Specify:	White, etc.
	3 Widowed 4 Divorce	ed										Wh	nite
	15. DECED (Specify only h	ENT'S EOUC	CATION Completed)		CEDENT'S			ON st of working	160	. KIND OF BUS	INESS/IND	USTRY	
<u> </u>	Elementary/Secondary (0-12		College (1-4 or 5+)	itte	. Do NOT u	se retired.)	during mo	si or working					
I I	Grade 12			Pl	umbei	r				Constru	actic	n	
COMPLETED	17. FATHER'S NAME (First, Midd	fin, Last)						16. MOTHER'S NA	ME (First,	Middle, Maiden	Sumame)		
BE	William Elwo	ood At	kins					Theres	a Ho	pe Shav	v.		
	19a. INFORMANT'S NAME (Type	Print)		19	b. MAILING	ADDRES	S (Street a	nd Number or Rural			_	Cortet	
2	Kristie Mari	e Atk	ins					gsville					3 20723
1	20s METHOD OF DISPOSITION 1 1  Cremation			20b. PLACE								City or Town	
	1 Burlai 2 Cremation 4 Donation 6 Other (S	3 Ramo	wal trom State	Sava	malory or o	ther plece)	3110N   Ma	ine of	1	14 Say			
	21. SIGNATURE OF FUNERAL S		Delet	Dava	ge ce			ID ADDRESS OF FA		14 Sav	rage,	Mary	Tano
- 1	11/1-	111	///			Do	onalo	dson Fun	eral	Home,	P.A.		
	X tell its	/ Xen	I will	5		3	13 Ta	albott A	ve.	Laurel	Mar	vland	20707
	23. PART I, Enter the diss	asea, or c	omplications that c	aused the de	ath. Do	not enter	the mo	de of dying, suc	h aa car	disc or respir	ratory arr	est,	Approximate
	IMMEDIATE CAUSE (Final	/	lst only one ceuse	on sech line	<b>.</b>								Interval Between Onset and Death
I	disease or condition		Ho	ad I	[mil	wie	C						Olisat and Death
ı	resulting in death)			R AS A CONSE									
_		_			G. o								
RTIFICATION	Sequentially list condition		DUE TO (OI	R AS A CONSE	OUENCE O	Et.						-	
AT	if any, leeding to immedia cause. Enter UNDERLYING					. 1.							
윤	CAUSE (Disease or Injury that initiated events	<b>S</b> (	DUE TO (OI	R AS A CONSE	OUENCE O	E.							
Ē	resulting in death) LAST					. ,.							
E E			l										
	PART II. Other significant	condition	contributing to de	eth but not	reaulting	In the ur	nderlylng	cause given in	Part I.	24a. WAS AN		24b. W	ERE AUTOPSY FINDINGS
2										PERFOR			MILABLE PRIOR TO OMPLETION OF CAUSE
									_	1)(C) YES 2	□ NO	0	F DEATH?
Σ	DID TOBACCO USE	CONITE	IDLITE TO CALL	SE OF DEA	TH V	с П :	NO F	LINICEDTAL				1	YES 2 NO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO I		IDOTE TO CAU		E OF DEA			UNCERTAI	ч Ц				
<u>5</u>	EXAMINER?		HOSPITAL:			OTHE	R:		V 20				
Ϋ́	27. MANNER OF DEATH		1 1 Inpatient 2 E		_			5 Realdence					
	1 Natural 5 Pe	ndina	26a. DATE OF IN. (Month, Day,			JURY		RK?		SCRIBE HOW IN			
B		estigation	6-10-9	25	220	9 "	1 🗌 Y	ES 2 NO	mo	for whi	de	collisi	in

1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)

261. LOCATION (Street and Number or Rural R sheppard

(Check only one)

street

In my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Day, Year) **JUNE** 11, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAME OF DEATH (ITEM 27) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201.

31. DATE FILED (Month, Day, Year) 4 1995

6 Could not be

3 Sulcida

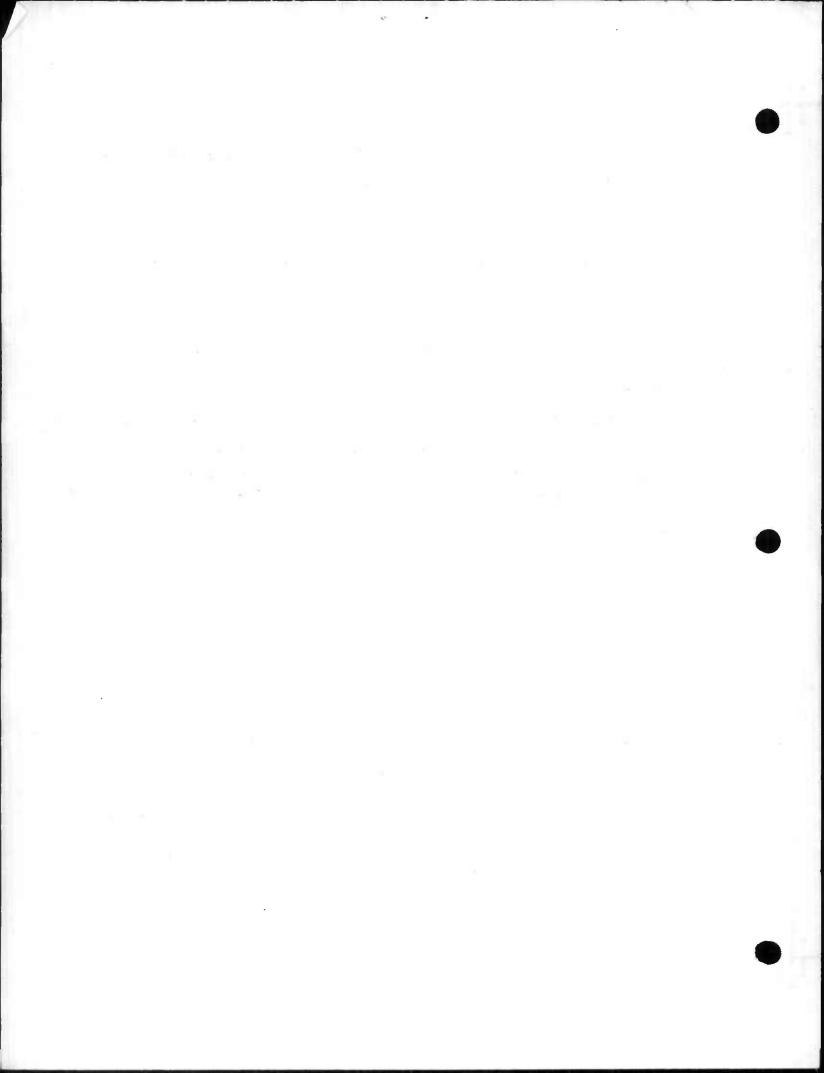
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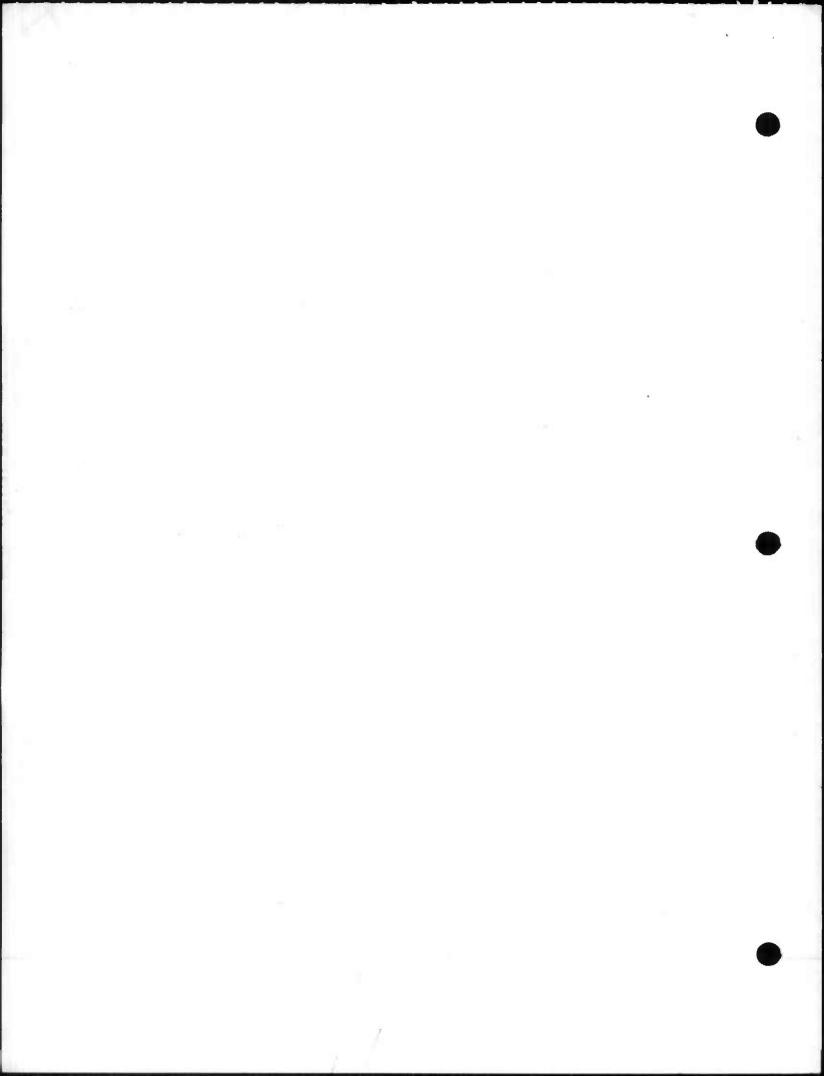
32. REGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

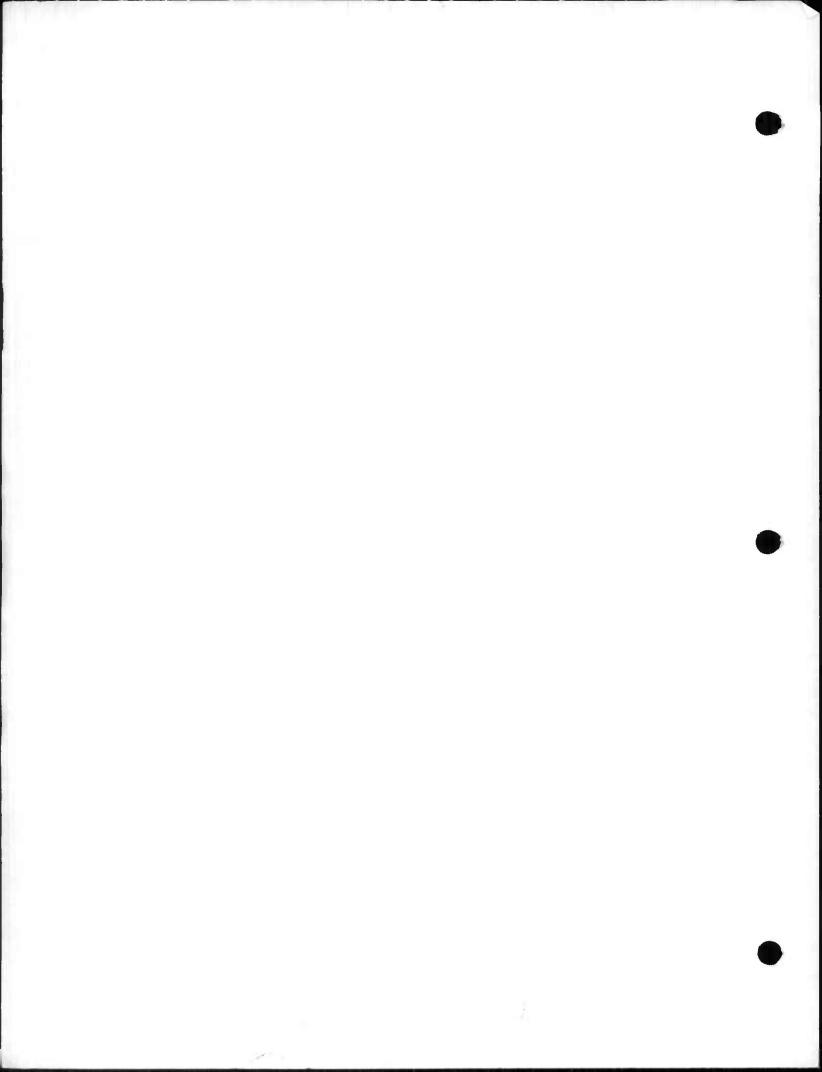
TO BE COMPLETED BY FINERAL DIRECTOR	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
i examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
lal.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by it
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - FOR STATE OF MARYLAND C	DEPARTMENT OF		MENTAL HYGIEN					
0.00	1. DECEDENT'S NAME (First, Middle, Lest) Albert Louis Bongiorni Sr.			Jun 0	2 19 <sup>8</sup>	3. TIME OF DEATH 5 5:43 P <sub>M</sub>			
0	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In O24-20-7998 1	YRS, MONTHS D	EAR IF UNDER 24 HRS. AYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) , 1928 Massachusetts  9c. COUNTY OF DEATH				
TOR	Malcolm Grow Hospital		ews Air For			nce George			
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR L	OCATION			10d. INSIDE CITY LIMITS?			
	Maryland Charles  100. STREET AND NUMBER	Waldorf	10f. ZIP CODE		10g. CITIZEN	1 YES 2 K NO OF WHAT COUNTRY?			
FUNERAL	4020 Night Heron Court		20603		USA				
B	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. A FORCES? TY LYES 2 Forces Type State F	NO il ye	S DECENDENT OF HISPAI S, specify Cuban, Mexica YES 2 NO Specif	T OF HISPANIC ORIGIN? (Specify Yea or No— phan, Mexican, Puerto Ricen, atc.)  10 Specify:  White					
COMPLETED	(Specify only highest grade completed)  Elementary/Secondery (0-12)  Collega (1-4 or 5+)	ECEDENT'S USUAL OCCU Give kind of work done during b. Do NOT use retired.)	PATION ng most of working	16b. KIND OF BU					
OM	17. FATHER'S NAME (First, Middle, Last)	nery Sgt.	18. MOTHER'S NA	US Mar:		ps			
BE C	Louis A. Bongiorni			Gazzaniga					
2		ob. mailing address (Sr 28 Charles				'			
	20e. METHOD OF DISPOSITION 20b DI ACE	AND DATE OF DISPOSITIO			CATION — City				
	Signature of Funeral Service Licensee								
ĺ	+ the of the	22. 1101	7 1 TO 1	10565	lain St	reet Fairfax,VA.			
CERTIFICATION	ahock, or heart feliure. List only one ceuse on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Arrhythmia  Due to (or as a consequence of):  Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST  Due to (or as a consequence of):  Due to (or as a consequence of):								
_	PART II. Other aignificant conditions contributing to death but not	resulting in the under	lying cause given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDICA				PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1YES 2 NO			
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA			N 🗆					
SICI	EXAMINER?  1 VES 2 NO  1 M Inpatient 2 ER/Outpatient:	CE OF DEATH (Check only OTHER: OTHER:	Home 5 Residence	8 Other (Specify)					
ВУ РНУ	27. MANNER OF DEATH  1 Natural 5 Pending (Month, Day, Year)  2 Accident Investigation	28b. TIME OF 28c	: INJURY AT WORK?	28d. DEŞCRIBE HOW I	NJURY OCCURE	D			
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, atreet, lectory,	office	281. LOCATION (Street City or Town, State)	end Number or R	ural Route Number,			
COMPLETED	29e. CERTIFIER (Check only one)  1  CERTIFYING PHYSICIAN: To the best of my knowledge, d  2  MEDICAL EXAMINER: On the basis of examination end/or					use(s) end manner as atated,			
BE	290. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	MBER	N .	NED (Month, Day, Year)			
10	Jeffrey Spillane, Maj, USAF	M 27) (Type, Print)	Malcolm Gr Andrews A	7 row Medica FB,MD 2033		02 1995 er			
	31. DATE FILED (Month, Day, Year)  JUN 08 1995  July Amelian Ray	all				DHMH-18 Rev 1/89			



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DIVISION OF VITAL RECORDS, P.O.	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be
-	-4
	M
	6

		1 - STATE REGISTRAR	STATE OF MARY	YLAND / DEPAF CERTIF	RTMENT OF H	HEALTH AND	MENTAL HYGI				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT		YEAR 3.	TIME OF DEATN	
		FRANCES BROWN  4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. lest birthday)	T (BIDED 4 VEAD		JUNE 8.	1995		3:05 A M	
Pin		155-01-2529  •• FACILITY NAME (# not institution, give s	1 🗆 M 2 🛣 F	98 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	JUNE 10, 1896 PENNSYLVA				
2, 3 should	DIRECTOR	96. FACILITY NAME (If not institution, give street end number)  COLLINGSWOOD NURSING HOME  RESIDENCE OF DECEDENT  96. CITY, TOWN OR LOCATION OF DEATH  96. COUNTY OF DEATH  MONTGOMERY									
ges 1,	JEC	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCA	TION			d. INSIDE CITY		
permit. Pages			GOMERY	R	OCKVILLE	3			LIMITS? XYES 2 NO		
	FUNERAL	100. STREET AND NUMBER 299 HURLEY AVENUE	<u>E</u>		10	20850			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
physician. burial-transit	S	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 YE	R IN U.S. ARMED	13. WAS DEC	CENDENT OF NISPA	Yea or No — 1	e or No — 14. RACE — American Indian.			
attending physe as the bur	ΒY	1 Never Married 2 Married 3 X Wildowed 4 Divorced	R DATES	1 TYES	,	Bleck, White, etc. Specify: WHITE					
- B	ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	WORK done during mo	ON ost of working	BUSINESS/INDU	STRY			
_a €	PLE	Elementary/Secondary (0-12)	Coffege (1-4 or 5 +)	HOMEM			OW	IN HOME			
by the hospital be detached to at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) HERSCHEL WOLO	WITZ			18. MOTNER'S NAME (First, Middle, Meiden Surname) UNKNOWN					
be retained ge 5 should e notified	TO BE	190. INFORMANT'S NAME (Type/Print) THOMAS BROWN (SO	ON)				ROAD, PO			<del></del>	
6 may stor, pa		20e METHOD OF DISPOSITION 1 25 Burtlel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	oval from State	20b. PLACE AND DATE	OF DISPOSITION (No	ame of	DATE 20c	LOCATION CI	ty or Town,	State	
Page al direc		21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AL	ND ADDRESS OF FA	CILITY				
0 = 0		· Oroberto	Lipo	um	1170	ROCKVILL	DBERG MEN E PIKE RO	CKVILLE	E. MD		
filled in to ion, or rei	2	23. PART I. Enter the diseases, prospective.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause or  Due to (or a	n each line.		de of dying, suc	th as cerdiac or re	eapiratory arres	st,	Approximate Interval Between Onset and Death	
B 2 2 2	NO	Sequentially list conditions,	a Preuno	NIS						48 hours	
ate be elecutivistician and control prior to burit	CATI	If any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									
eath certificate be a attending physician mal Hygiene prior to y, or other traun	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE O	F):						
Me Me		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
ed by th and	MEDICAL	Organia demontra							IRABLE PRIOR TO MPLETION OF CAUSE DEATH?		
w requires been sign or, of Healt 3 shows		HIP Surgery  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES   NO   UNCERTAIN									
E 8 5 7	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT	TN (Check only one)	OTTELNIAN					
ician: ertifica the Sta	IVSI	1 TYES 2 NO	HOSPITAL: 1   Inpetient 2   ER/O		-	e 5 🗆 Residence	8 Other (Specify)				
PHY:	ву Рн	27. MANNER OF DEATN  Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJUR (Month, Day, Year			RK?	28d. DESCRIBE NO	W INJURY OCCU	RED		
TTENDI TOR: A after da 28 is	B	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJU building, etc. (S	IRY — At home, farm, specify)	street, fectory, offic		281. LOCATION (Str. City or Town, St	et end Number or ete)	Rurel Route	Number,	
OB DIR	COMPLET		ICIAN: To the best of my kn								
HOSPITAL FUNERAL WITHIN 72 I	00	2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF OUTTIFIER	R: On the basis of examine	tion and/or investigatio	n, In my opinion, d			, end due to the	cause(e) and	f menner ee stated.	
TO THE HOSPI TO THE FUNER De filed within	BE					29c. LICENSE NUI	MBER	29d. DATE S	HONED (Mor	nth, Day, Year)	
FFA	5	30. NAME AND ADDRESS OF PERSON AND PARTY ME	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	Print)	Rock	V1/10 A	10 20R	E 0,	1333	
5		31. DATE FILED (Month, Day, Year)						200	70		
		JUN 09 1995 3	32. REGISTRAR'S SU	ardally							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher of hours after death. Page 6 may be retained by the hospital or attending physician.

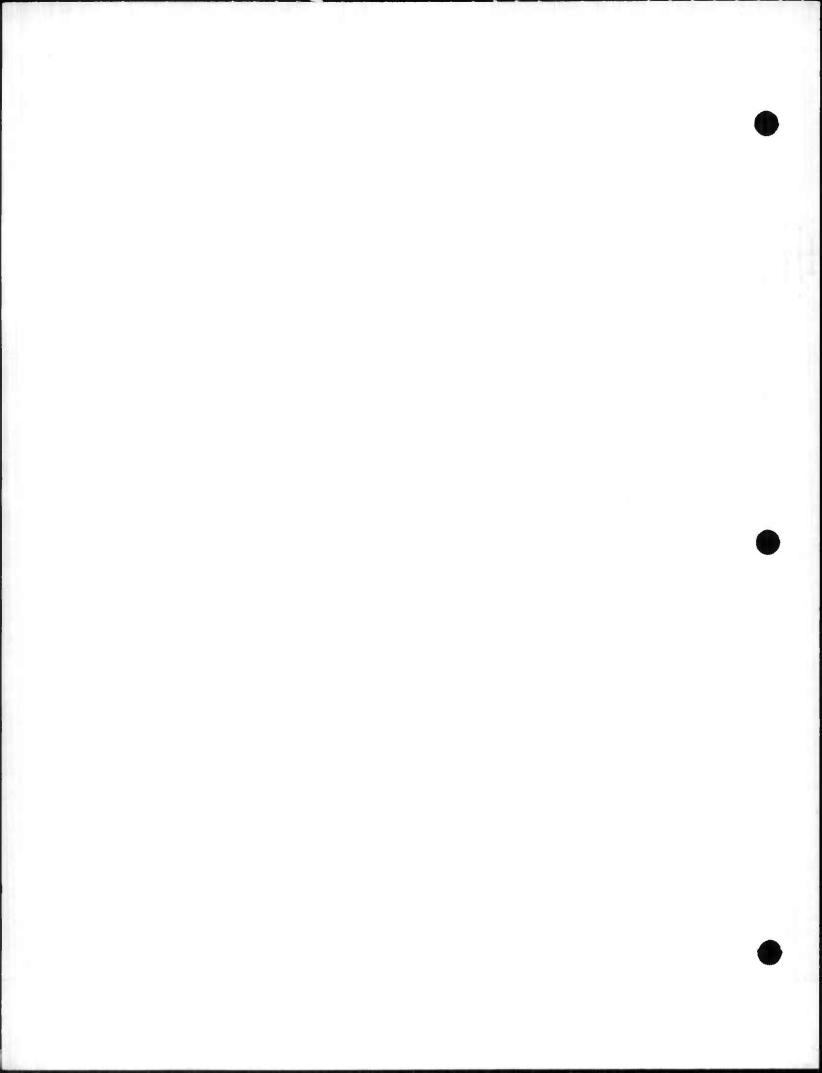
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle Leet								HEG				
	James Curt		chy							June 5,	DAY	O.F.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. In:	it birthday)	IF UNDER	1 YEAR	IF UNDER	24 MDC	7. DATE OF BIRT		195	e BIRTUR	3:00 P M
	217-14-4959	)	1 🖳 M 2 🗌 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Y	ar)	, ,	Country	
	9a. FACILITY NAME (If not in	12							Mary					
E C	Holy Cross Hospital					Silver Spring Montgomer  Montgomer								
5	RESIDENCE OF DECEDENT					<u> </u>	TIVE	т эрг	LING			MC	nitgo	mery
DIRECTOR	10a. STATE 10b. COUNTY				10c. CIT	Y, TOWN C								10d. INSIDE CITY LIMITS?
	Maryland Montgomery												1 YES 2 X NO	
FUNERAL							101	. ZIP CODI				10g. CITIZEN OF WHAT COUNTRY?		
W	4701 Adrian	Stree				20853 U.S.								
	1 Never Married 2 🖺	Merried	12. WAS DECEDEN FORCES? 1	YES 2 1			If yes, sp	ecify Cube	n, Maxicai	IIC ORIGIN? (Speci n, Puerto Rican, et	ly Yea≀ ∴)	or No—	14. RACE Black,	- American Indian, White, etc.
BY	3 Widowed 4 Divo	rced	IF YES, GIVE W	AR OR DATES			1 🗌 YES	2X NO	Specify	r;			Specify Whi	
0		EDENT'S EDUC	CATION	16a. DE	CEDENT'S					16b. KIND O	F BUSI	NESS/IND		Le
COMPLETED	Elementary/Secondary (0		College (1-4 or 5	- Bloo	Do NOT u	work done : se retired.)	during mo	st of worldn	g					
MPI			5+	P1u	mbing	g Ins	spec	tor		Feder	al	Gove	rnme	nt
00	17. FATHER'S NAME (First, Mi	ddle, Last)						18. MOTH	HER'S NAI	ME (First, Middle, M	alden S	iumame)		
BE	Charles Mar		Beachy							padwater				
2	194. INFORMANT'S NAME (7)									Route Number, City of				
	Margaret E.		ny	4	701	Adria	in S	treet	Re	ockville	, Ma	ryla	nd 2	0853
	20a. METHOD OF DISPOSITI 1 IX Burlet 2 ☐ Cremetto	n 3 🗆 Remo	oval from State	cemetery, cre		shee elecat				1			City or Tow	4
- 49	4 Donation 6 Other  21. SIGNATURE OF FUNERAL	. ,,	ENGEE	Gate	of He	leaven Cemetery 6/8/95 Silver Spring, Maryland								
	1 - 0									lins Fun	era	1 Ho	me.	Inc.
	Land		Long			50	00 U	niver	rsity	Blvd.	W.	Sil.	Spr.	MD 20901
	23. PART I. Enter the di shock, or he	seases, or c lert fallure. I	omplications the List only one cau	t coused the de se on each line	ath. Do r	ot enter	the mo	de of dyi	ng, auch	as cardiec or	eapir	story arm	est,	Approximata Interval Batween
	IMMEDIATE CAUSE (Fine)													
	s. Chronic Obstructive Lung Disease Years													
_	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):													
B	cause. Enter UNDERLY	NG												
Ē	CAUSE (Disease or injusted initiated events		DUE TO	OR AS A CONSE	DUENCE OF	F):								
ᇤᆙ	resulting in death) LAST		ś											
	PART II. Other aignifica	nt conditions	a contributing to	daeth but not r	esulting	n the un	deriving	Cause o	dven in I	Part i 24a W	C AM A	Impev	245 1	VERE AUTOPSY FINDINGS
EDICAL	Cerebral Infarction with Mult. Infarct Dementia							WAILABLE PRIOR TO COMPLETION OF CAUSE						
										- 1 D Y	S 2X	NO	(	OF DEATH?
Σ	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	s हा ।	NO F	LINC	ERTAIN				'	YES 2 NO
<b>₹</b> ∥	25. WAS CASE REFERRED TO				E OF DEAT			0110	LKIZII	101				
Sic	EXAMINER?		HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER		e 5 🗆 Re	aldence	8 Other (Specify				
PHYSICIAN:	27. MANNER OF DEATH	1.99	26a. DATE OF (Month, Di		28b. TIM	E OF	28c. INJ	URY AT		26d. DESCRIBE H		JURY OCC	URED	
BY		Pending Investigation	(month, b)	ay, rour,	ING	URY		RK? YES 2 [	NO					
	3 Suicide 6 0	Could not be	26a. PLACE Of building,	F INJURY — At ho	me, farm, i	treet, fact	ory, offici			261. LOCATION (S	reet an	d Number	or Aural Ro	ute Number,
3 Suices 6 Could not be determined building, etc. (Specify)  29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner one)														
2	29e. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurre	d at the ti	ma, date	and place,	and due	to the cause(s) and	mann	er sa state	ıd.	
S S	one) 2 MEDIO	CAL EXAMINER	R: On the basis of ex	amination and/or i	nvestigatio	n, In my o	pinion, d	eath occur	ed at the t	tima, date and plac	s, and	due to the	cause(a) a	and manner so stated.
BE	296. BIGNATURE AND TITLE	OF CERTIFIER	> .					29c. LICE	NSE NUM	BER	T	29d. DATE	SIGNED (A	fonth, Day, Year)
2	Meeting	- 0	Layel	W				D C	8944	+		▶ Ju	ne 6	, 1995
-	30. NAME AND ADDRESS OF		1.3											
	Martin C. Sh			720 Far	ragut	Ave	nue	Ken	sing	gton,Mar	y1a	nd 2	0895	
	31. DATE FILED (Month, Day, )			R'S SIGNATURE										
	JUN 08	1995	Julia Me	relica Par	4									
			1.1											DUMM 16 Day 1/00



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31. DATE FILED (Month, Day, Year)

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) M-D

132. REGISTANT'S SIGNATURE

Vaid

35 1995

	if. P		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. P	be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.	
	_		

95 18943 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 30 WERS 118611 MONTH DAY

May 29th

7. DATE OF BIRTH
(Morth, Day, Year)

OCT 3kd 190 7 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. BIRTHPLACE (State or Foreign
Country) 578 62 1 X M 2 - F 1206 DAYS HOURS 90WA YRS 9a. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 8806 Z32dAVe tyaltsville P. G Country DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Prince Georges HYATTSVIL 1 YES 2 NO COMPLETED BY FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Ave 8806 2351 15A 20783 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. ☐ Never Married 2 ☐ Married 3 Widowed 4 Divorced WW TI 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) ). S. Post office Postal 2 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) BOWERS notified at ee. MAY BE ALTA TOLAND 19a. INFORMANT'S NAME (Type/Print) 2 Nelson Caraline Brentwind come Md. 20693 must be 20a, METHOD OF DISPOSITION
1 N Burlat 2 Cremation 3 Rer 20b. PLACE AND DATE OF DISPOSITION (Name of OATE metery, cremetory or other place)
Md. VA. Cemetry Donation 5 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 20012 I'm bashinglon Takoma Funcial Hor 254 carral Strat Kome lose 23. PART I. Enter the diseases. o N medical es, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or reapiratory arreat, shock, or heer fallure. List only one ceuse on each line. Intervel Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition Cardio ful monary
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) 23 shows any Injury, or other traumatic event, Aspration Proumonia PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury COLONDRY Arleby DUE TO (OR AS A CONSEQUENCE OF): that initiated events Decubitus resulting in death) LAST Intelled 10 days PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Multiaglicular 08/earltita 1 TYES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO OTHER 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) Item 28 is COMPLETED 6 Could not be 4 Homicide determined 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as atated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. BUCHATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D17843 5/30/93

3311 Talido Terrace Hyaltsvilla

559-3500

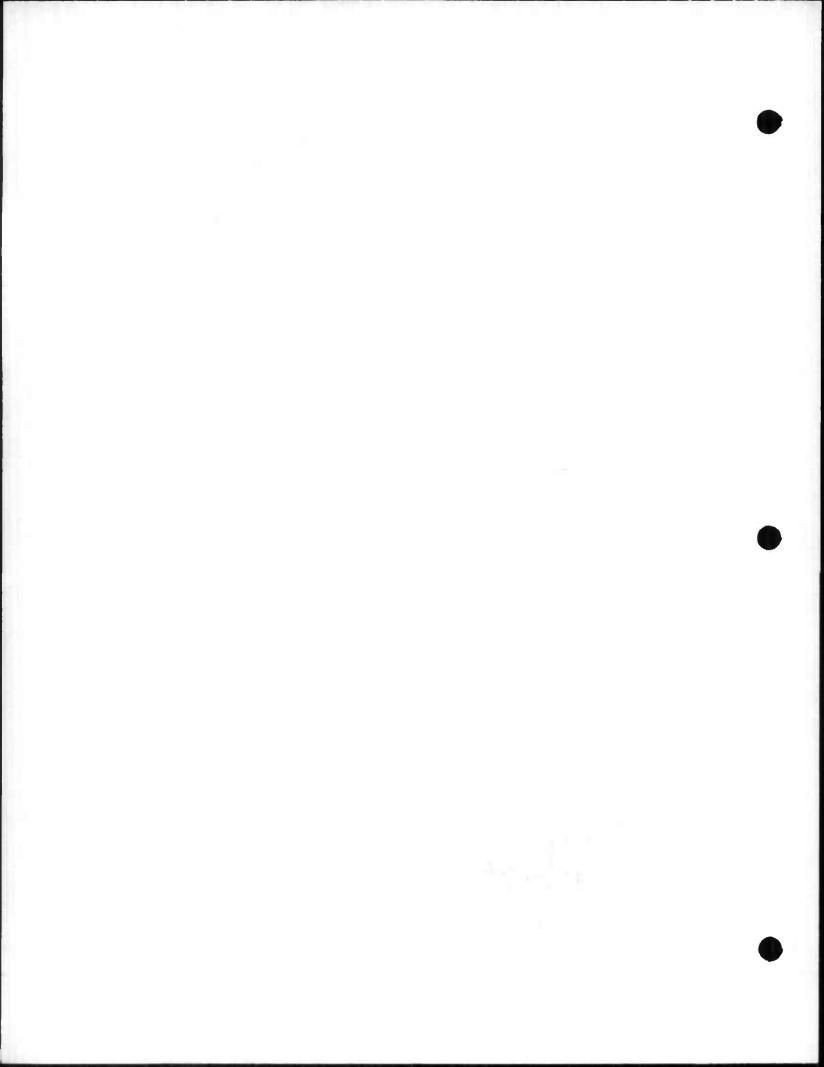
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	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermin Planes 1.2 a should
O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detected for use as the burial-transf normin Pages 1.2 should	be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
***O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	<b>DEPARTMENT</b>	OF HEALTH	AND	MENTAL	HYGIENE
	CF	ERTIFICATE	OF DEAT	TH		REG. NO

	1 - FOR STATE REGISTRAR	TE OF MARYL	AND / DEPAI CERTIF	RTMENT	OF H	EALTH AND DEATH	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)							TE OF DEATH			3. TIME OF DEATH
	Virginia Elizab	eth Bloch	er				Jun	e 7, 19	995	YEAR	1:25 A M
	4. SOCIAL SECURITY NUMBER 5. SEX	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS HOURS MIN. (Month, Day, Year)						8. BIRTH	IPLACE (State or Foreign		
	210 10 4/00				DAYS	HOURS MIN.		e 1, 19	923	3 Maryland	
œ	Se. FACILITY NAME (If not institution, give street and	number)		9b. CITY,	TOWN 0	R LOCATION OF D	DEATH		9c. COL	NTY OF D	EATH
5	109 Forest Avenue Rockville Montgomery								ery		
DIRECTOR	10e. STATE 10b. COUNTY		10c. Ci1	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY
	Maryland Montgome	Ro	ckvil	lle						LIMITS?	
AL	10e. STREET AND NUMBER				101.	ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?
FUNERAL	109 Forest Avenue					20850			Uni	ted :	States
2	11. MARITAL STATUS  1 Never Married 2 Married  12. WA	S DECEDENT EVER IN	U.S. ARMED			ENDENT OF HISPA			s or No-	14. RACE Black	— American Indian,
B	3 Widowed 4 Divorced	YES, GIVE WAR OR D	ATES			2 K NO Speci		, , , , , , ,		Speci	ty:
	15. DECEDENT'S EDUCATION		16a. DECEDENT'S	USUAL OC	CUPATIO	N	1	6b. KIND OF BU	ISINESS/IN	DUSTRY	White
Ē,	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	od) pe (1-4 or 5+)	(Give kind of life. Do NOT u	work done o	luring mos	st of working		05. 7.1175 07 50	, O.II VE 0 0 / III V	DOGTA	
MP.	- 3		Registe	red N	Jurs	e		Hospita	1		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N					
H	Frederick Yomme	er				Joanne	Pa:	lmer			
2	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural					
	Joseph P. Blocher		109 F	orest	Av	enue, Ro	ockv:	ille, M			20850-2805
	20s. METHOD OF DISPOSITION  1Xi Burial 2 Cremation 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  20c. LOCATION — City or Town, State										
	Gate of Heaven Cemetery Silver Spring, Maryland  21. SIGNATURE OF FUNERAL SERVICE UCENSEE  Silver Spring, Maryland  22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral  HOME / Rethered as Chevy Change										
	· M. Th	4		1110	me/ 1	e chesuc		EVY CITE	ise.	Inc.	/25/
	My D Julia	M006		Wis	con	sın Aver	lue,	Bethes	da.	MD 20	0814-3501
	23. Port I liner the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest,  Approximate Interval Between										
									Onset and Death		
ŀ	resulting in death)  a. Pulmonary-cardiac arrest  DUE TO (OR AS A CONSEQUENCE OF):										
_											
흔	Sequentially list conditions, if any, leading to immediate								2 d.		
S	CAUSE (Disease or injury								30 years		
빝	that initiated events		CONSEQUENCE O								
CERTIFICATION	('Orobrows and dead dead									10 years	
7	PART II. Other significent conditions contri	ibuting to death be	ut not reaulting	n the un	derlying	cause given in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDIC	Status post tracheos	tomy						1 TYES			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME											OF DEATH?  1 YES 2 NO
	DID TOBACCO USE CONTRIBUTI	TO CAUSE O	F DEATH YE	S   N	10 🗆	UNCERTAI	NE				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	PITAL:	26. PLACE OF DEA								
YSI	1 YES 2 NO 1 In	patient 2 - ER/Outp	ntient 3 🗆 DOA	OTHER		5 💯 Residence	6 🗆 Otf	ner (Specify)			
	27. MANNER OF DEATH  1 K Natural 5 Pending	(Month, Day, Year)	26b. TIM	E OF URY	28c, INJU WOF	RK?	26d. DI	ESCRIBE HOW	NJURY OC	CURED	
≧	2 Accident Investigation	e. PLACE OF INJURY	At home down	M		ES 2 NO					
	3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Spec	ify)	ntreat, recto	ту, отнев		Cit	CATION (Street by or Town, Stete)	and Number	or Rural R	oute Number,
9 1	29e. CERTIFIER	the head of our board									
COMPLETED	(Check only one)  2 MEDICAL EXAMINER: On the										and account of the same
	29b. SIGNATURE AND TITLE ON CERTIFIER				1			ta and place, ar			
<b>#</b>	// // /	MD				D40353	MBER				(Month, Day, Year)
유 🖁	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEA	ATH (ITEM 27) (Type.	Print)		D40353	_		- 01	ine 8	, 1995
	James Yan, M.D. 5530	Wisconsi	n Avenue		i to#	1045 0	ho	Chas	1470	2003	r
	31. DATE FILED (Month, Day, Year) 32	BEGISTRAR'S SIN	TURE	, 30	T 06#	1045, C	пеуу	Chase	, MD	2081	5
	JUN 09 1995 Juli	Mudlarka	tall								
-											DHMH-16 Rev 1/89



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1	1.0	ECI	EDE	NT C	8

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	A	EG. NO.				
100	1. DECEDENT'S NAME (First, Middle, Last)		RANDT			2. DATE OF O	ď.	LI	995	3. TIME OF OEA	PM
9	4. SOCIAL SECURITY NUMBER 104-38-5167	1 □ M 2XXF	47 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De JULY	HRTN y, Year) 28,	1947	Countr	PLACE (State or Final) W YORK	oreign
DIRECTOR	90. FACILITY NAME (If not institution, give str SHADY GROVE ADVENT RESIDENCE OF DECEDENT		AL	96. CITY, TOWN OR LOCATION OF DEATH  ROCKVILLE  MONTGOMERY							
EC	10a. STATE 10b. COUNTY		10c, CITY	, TOWN OR LOCAT	ION				7	10d. INSIDE CITY	
	MARYLAND MONT	GOMERY		POTOMAC	ZIP COOE					1 YES 2	
FUNERAL	11508 EVELAKE COUR				20878 UNITED STATES						
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2XXNO	If yes, spe	ENDENT OF NISPANI relity Cuban, Mexican 2 NO Specify:	, Puarto Rican	becify Yea i, stc.)	or No-	14. RACE Black Speci	— American Indi k, White, atc.	en,
COMPLETED	(Specify only highest grade completed)			usual occupation ork done during most retired.)							
2	17. FATHER'S NAME (First, Middle, Last)										
BE CC	LOUIS KRI	EG			18. MOTHER'S HAM SHIRLE	EY	GOL:	DBERG			
٩	JOSEPH BRANDT (HUS		196. MAILING	EVELAKE	CT., N.	POTOM.	AC,	wn, State, Zip Code) MD 20878			
	20e, METHOD OF DISPOSITION 1 iD Surfal 2 Credition 3 Remote 4 Donation 5 Other (Specify)	OB. PLACE AND DATE OF	F DISPOSITION (National MEMORIA	AL GDN.	6/6		LS CI		wn, Stata H, VIRGI	INIA	
	21. SIGNATURE OF TUNERAL SERVICE LICE	•	DANZA	D ADDRESS OF FAC NSKY-GOLI	BERG	MEMO!	RIAL	CHAI	PELS, IN		
$\neg$	22 BADY I Show the discusse of	1. / 22	11		ROCKVILLE					MD 208	352
	23. PAHT I. Enter the disease of coahock, or heart fallers. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	Can	and line.	espi	vata	an cardlec	or reapir	207	Post,	Approxim interval B Onset and	etween
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury Cause).										
SERTIF	that initiated events reaulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF CAUTO IN MULL)										
- 11	PART II. Other aignificent conditions	contributing to death	but not resulting in	the underlying	ceuse given in P	art i. 24a	WAS AN	AUTOPSY	24h	WERE AUTOPSY F	INDINGS
MEDICAL							PERFORI	MED?	1	AVAILABLE PRIOR COMPLETION OF C OF DEATH?	10
	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH YES	S I NO IV	UNCERTAIN					1   YES 2	NO
A	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTELRIAIT						-
Sic	EXAMINER?	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/O		OTHER:	5 🗆 Residence 8	Other (Spi	ic//v)				
BY PHYSICIAN:	27. MANNED OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year	Y 28b. TIME	OF 28c. INJU	IRY AT	28d. DESCRIB		JURY OCC	CURED		
9	3 Suicide 6 Could not be determined	28a. PLACE OF INJUI building, atc. (Sc	RY — At home, farm, at becily)	reet, factory, office		261. LOCATION City or Tox	(Street ar	nd Number	or Rural R	oute Number,	
COMPLET		AN: To the best of my kno									
w	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examinat	ion and/or investigation	, In my opinion, de	oth occured at the ti		place, and			(Month, Day, Year)	tated,
TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPONETED CAUSE OF I	DEATH (ITEM 27) (Type, I	Print)	0217	126		10	un	e 1, 19	9.5
	15 2 25 S N 31. DATE FILED (Month, Day, Year)	ady Gra	ove Road	, Koy	Kville,	ma-	ry la	and	02	085	0
	JUN 07 1995 Ja	hi devoluter to	ardall 1	1 4							

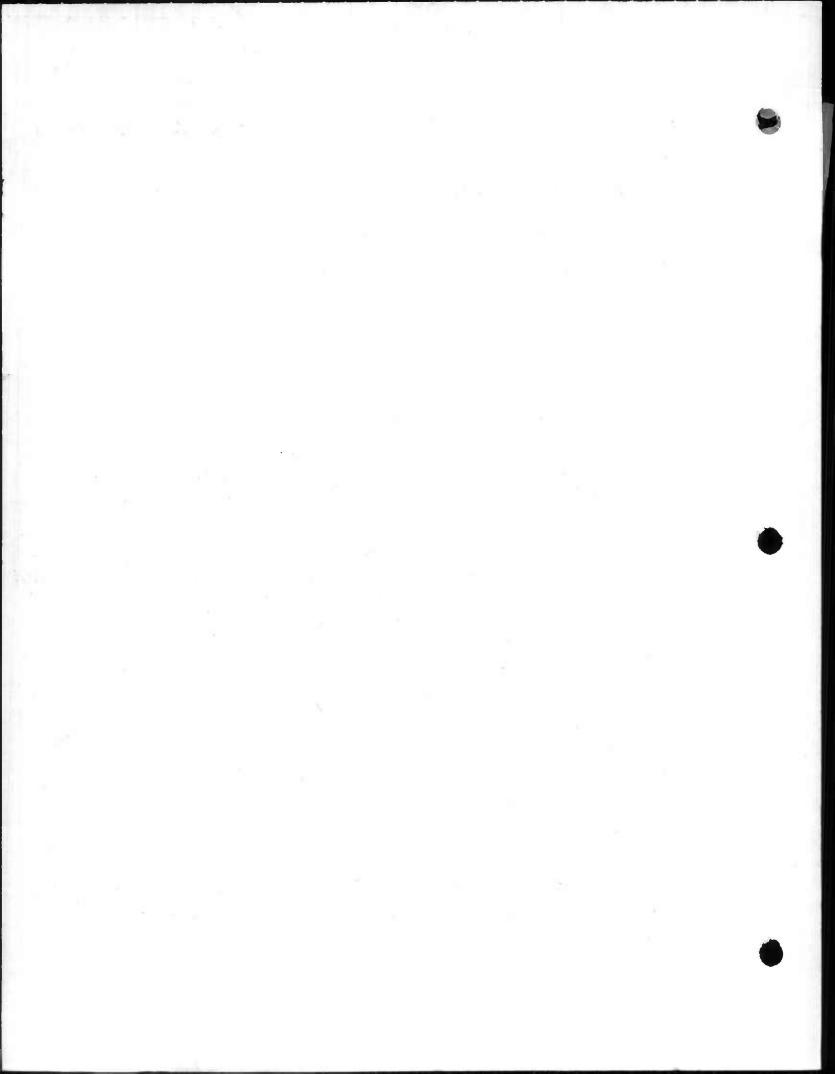
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zerhours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89

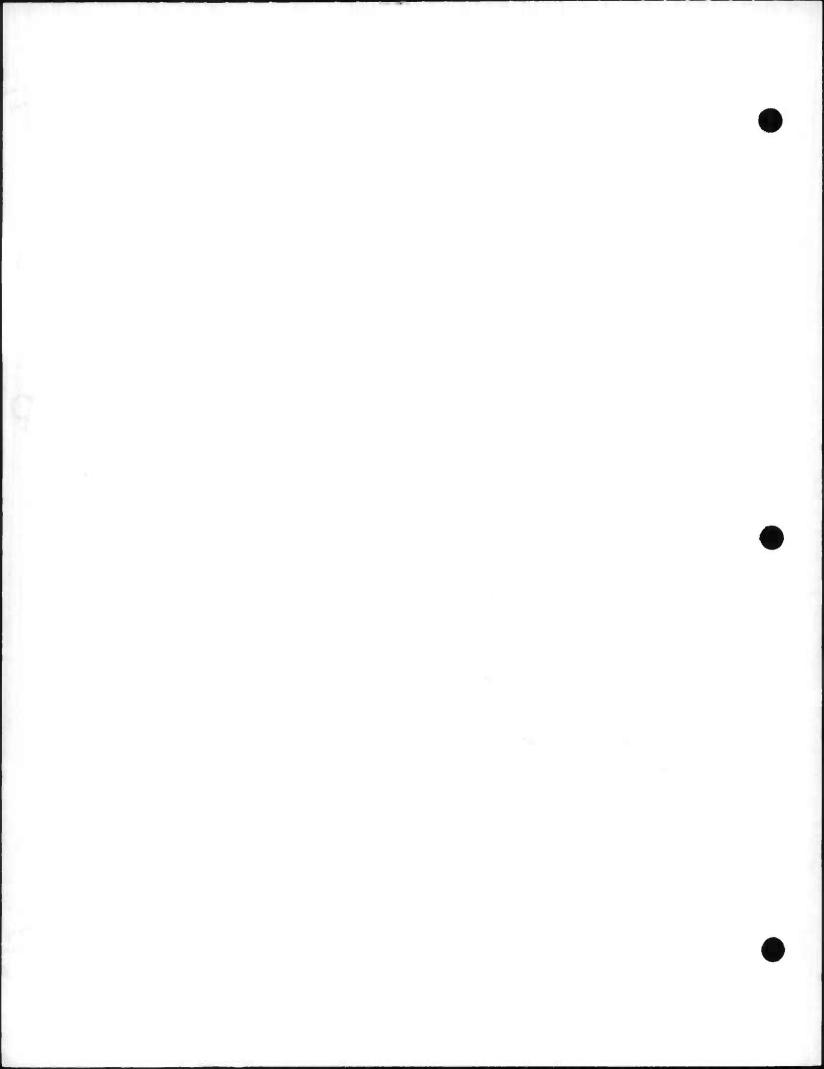


DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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SOCIAL SECURITY MUNICER  213-74-9436  1											
See PRESENTED AND FORMER AND PROMERY SILVER SPING WAS PROCEDED TO THE STATE OF THE											
Be. FACILITY MAME (in the institute, give areas and number)  10. SILVER Spring  10. Spring  10. Spring  10. Spring  10. Spring  10. Spring  10. Sp											
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15. DECEDENT'S EDUCATION [Specify only Impliest grade completed) [Elementary/Secondary (1-2)] [Elementary/Secondary (1-2)] [In PATHER'S HAME (First, Middle, Last)] [The FATHER'S HAME (First, Middle, Last)]  15. NOTIONANT'S HAME (First, Middle, Last)]  16. NOTIONANT'S HAME (First, Middle, Last)]  16. NOTIONANT'S HAME (First, Middle, Last)]  17. FATHER'S HAME (First, Middle, Last)]  18. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)]  19. NOTIONANT'S HAME (First, Middle, Last)											
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19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  19e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT'S NAME ("IpperPrint")  10e. INFORMANT SNA											
Sam V. Benedetti    100											
20s. METHOD OF DISPOSITION  1 REPHOLO OF DISPOSITION  1 REPHOLO OF DISPOSITION  1 REPHOLO OF Clemetion 3 Removal from State  20s. METHOD OF DISPOSITION (Name of cemelor), crematory or other place)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Francis J. Collins Funeral Home, Inc.  500 University Blvd., W. Sil.Spr., MD 209  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, interval diseases or condition  resulting in death)  Sequentially list conditions, ill any, leading to immediate cause. Enter UNDERLYING  CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  1 YES 2 NO.  NAMEDIATE 20c. LOCATION — City or Town, State 20c. LOCATION — City or To											
Colling Funeral Service Licensee   Cate of Heaven Cemetery 6/5/95   Silver Spring, Mary 1											
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil.Spr., MD 209  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, interval disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury)  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):  1											
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If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  d.  DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  PART II. Other significant conditions contr											
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PART-II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24s. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO NO COMPLETION OF OF CENTRY  1 YES 2 NO NO PERFORMED?											
PART-II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24s. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO NO COMPLETION OF OF CENTRY  1 YES 2 NO NO PERFORMED?											
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District molletin Control attrophy Grain Tumpy    1   YES 2   NO   1   YES 2   YES 2   YES											
25 WAS CASE REFERRED TO MEDICAL											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  28. PLACE OF DEATN (Check only one)  EXAMINER?  OTHER:											
EXAMINER?  1 YES 2 NO  1 Properient 2 ER/Outpetlent 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify)  27. MANNER OF DEATN  28. DATE OF IN HISTY  29. TIME OF 120. MAINTER OF											
2 Accident Investigation M 1 YES 2 NO											
3 Suicide 8 Could not be determined 28. Could not be determined 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29e. CERTIFIER											
(Check only   CEHTIFTING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.											
S ORB) 2 MEDICAL EXAMINED: On the bests of examination and/or level an											
one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as											
296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (North) Only Your											
296. SIGNATURE AND TITLE OF CHILDREN  296. LICENSE NUMBER  296. LICENSE NUMBER  297. LICENSE NUMBER  298. SIGNATURE AND TITLE OF CHILDREN  298. SI											
296. SIGNATURE AND TITLE OF CENTRE IN 1992  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (1997) No. 1992  30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)											
296. SIGNATURE AND TITL OF CENTRE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (NUMBER) 297. DOZ 338 296. DATE SIGNED (NUMBER) 298. LICENSE NUMBER 298. DATE SIGNED (NUMBER) 299. LICENSE NUMBER 299. DATE SIGNED (NUMBER) 290. DATE SIGNED (NU											
296. SIGNATURE AND TITL OF CENTRE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (NUMBER) 297. DOZ 338 296. DATE SIGNED (NUMBER) 298. LICENSE NUMBER 298. DATE SIGNED (NUMBER) 299. LICENSE NUMBER 299. DATE SIGNED (NUMBER) 290. DATE SIGNED (NU											

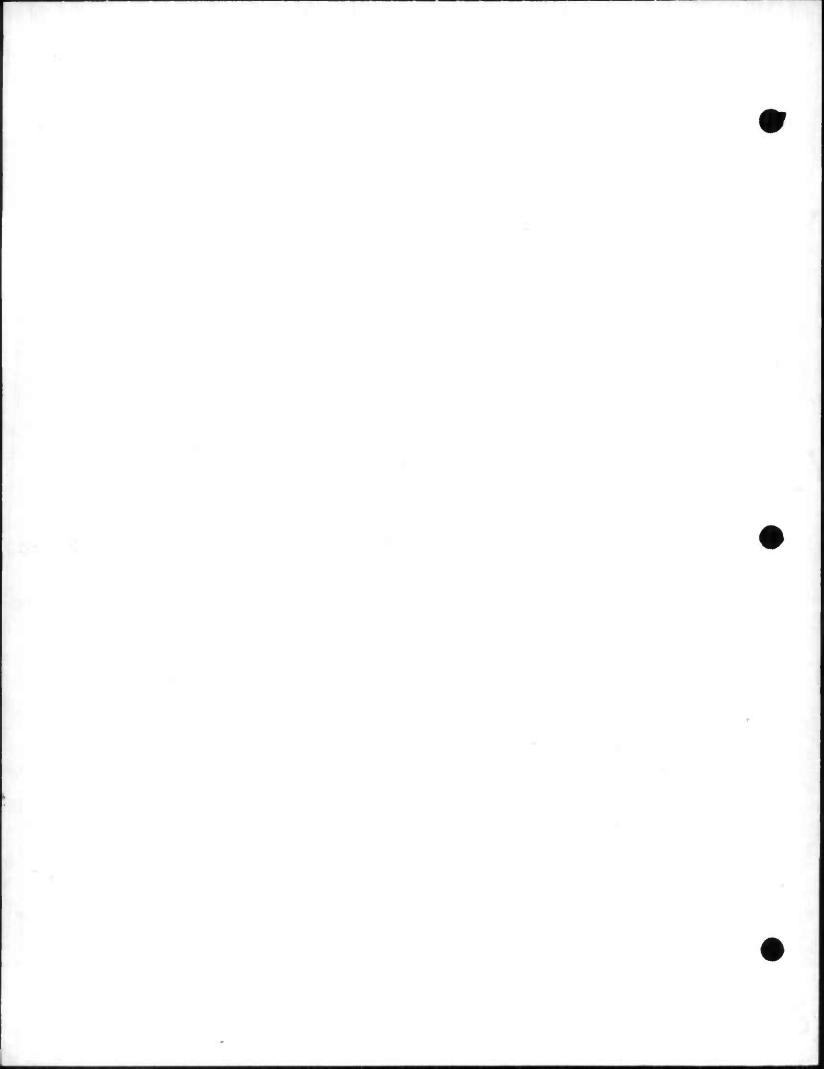


permit. Pages 1, 2, 3 should

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	10 THE FUNEMAL DIRECTORS AND THE DISCOUNTED HIS DEED SIGNED BY THE BENDING PRYSICIAN AND COMPRERY MIRED IN DIVIDE THE PROPERTY AND ADDRESS STOUID DE GENERALD NOT USE AS THE BURISH TRANSITY OF THE PAYOR THE WITHIN 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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A.	nended #1 6/6/9	< m	PT	m	Instal	me	nn	85		8947	
	1 - STATE OF N	MILL CAMP /	DEFAR	TMENT OF H	IEALIN AMU	MENTA	L HYGIEN		J(7()	7	
A	1. DECEDENT'S NAME (First, Middle, Last)	10.0 M	RVIS	O'Nei	11 Bishoi	MONT	_	AY 1 9	YEAR 995	7:02 A. M	
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 ☑ F	6. AGE (in yrs. les	t birthday)YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURG MIN.	7. DATE (Mont	OF BIRTN th, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign	
R	8a. FACILITY NAME (If not institution, give atreet and number)  Montgomery General Hospi			оь. city, тоwn с			. 0, 1	9c. COUNTY OF DEATN			
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY		10c. CITY	, TOWN OR LOCAT				Me	Montgomery  10d. INSIDE CITY LUMITS?		
	Maryland Montgomery 100. STREET AND NUMBER		Ga	ithersb	urg		<u>-</u>	1 YES 2 NO			
FUNERAL	19532 Burlingame Way 11. MARITAL STATUS 12. WAS DECEDEN	EVER IN U.S. AR	MED	13. WAS DEC	20879 ENDENT OF NISP	ANIC ORIGI	N? (Specify Va	Uni	ted S	tates	
BY	1 Never Married 2 Merried FORCES? 1 3 Wildowed 4 Divorced FYES, GIVE W	YES 2 X	10	II yes, sp	2 X NO Spec	can, Puerto	Rican, atc.)	U NO -	Black, Specify	White, etc.	
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 8 +	(G	CEDENT'S ive kind of w Do NOT us	USUAL OCCUPATION of done during mo-	ON st of working	166	. KIND OF BU	SINESS/INC	DUSTRY	MILCO	
COMPL	12 17. FATNER'S NAME (First, Middle, Last)		ail H	andler	18. MOTNER'S N				vice	Company	
BE	James Clark O'N		h MAII INC	ADDRESS (Street a		Li1	llian	May	Hunr	1	
10	Patty Brown	19	9532	Burlinga	ame Way,	Gait	hersb	urg,	MD. 2		
	1 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21_SIGNATURE OF FUNERAL SERVICE LICENSES A	cemetery, cre	matory or oti	aven Cer	netery	6/7	7 Sil			n, Stata g, Maryland	
1	Mulian D. C.	elile	u		D ADDRESS OF		DeVol			MD. 20877	
	23. PART I. Enter the disease, or complications that shock, or heart fellure. Liet only one ceu iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	se on eech iina	. F E	ot enter the mo	de of dying, eu	ich aa can	diac or reepl	iratory an		Approximeta interval Between Onset and Death Two YEARS	
Sequentieity list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other algnificant conditions contributing to	death but not r	eaulting in	the underlying	csuse given i	n Part I.	24a. WAS AN PERFOR 1 TYES 2	MED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO	
EXAMINER?  1   YES 2 NO									TUBER		
										at a	
ETED	4 Nomicide detarmined	Mc. (Specify)				Clty	ATION (Street a or Town, State)			ne Number,	
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of ax									and manner as stated.	
BE	296. SIGNATURE AND TITLE OF VEHTOUR	Ilv	n	10	29c, LICENSE N	WBER (		29d, DAT	E SIGNED (A	7 . 199 T	
2	30. NAME AND ADDRESS OF TERSON WHO COMPLETED CAUS	E OF DEATH (ITE	1 27) (Type,	Print) D()	nu P	hile	M.	0/1	84,7	DD JO83]	
		S SIGNATURE	1.11			11/ /2/		(*	, ))	0,000	
ايب	()	CONTRACTOR OF THE PARTY OF THE	4.4							DNMN-18 Rev 1/89	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

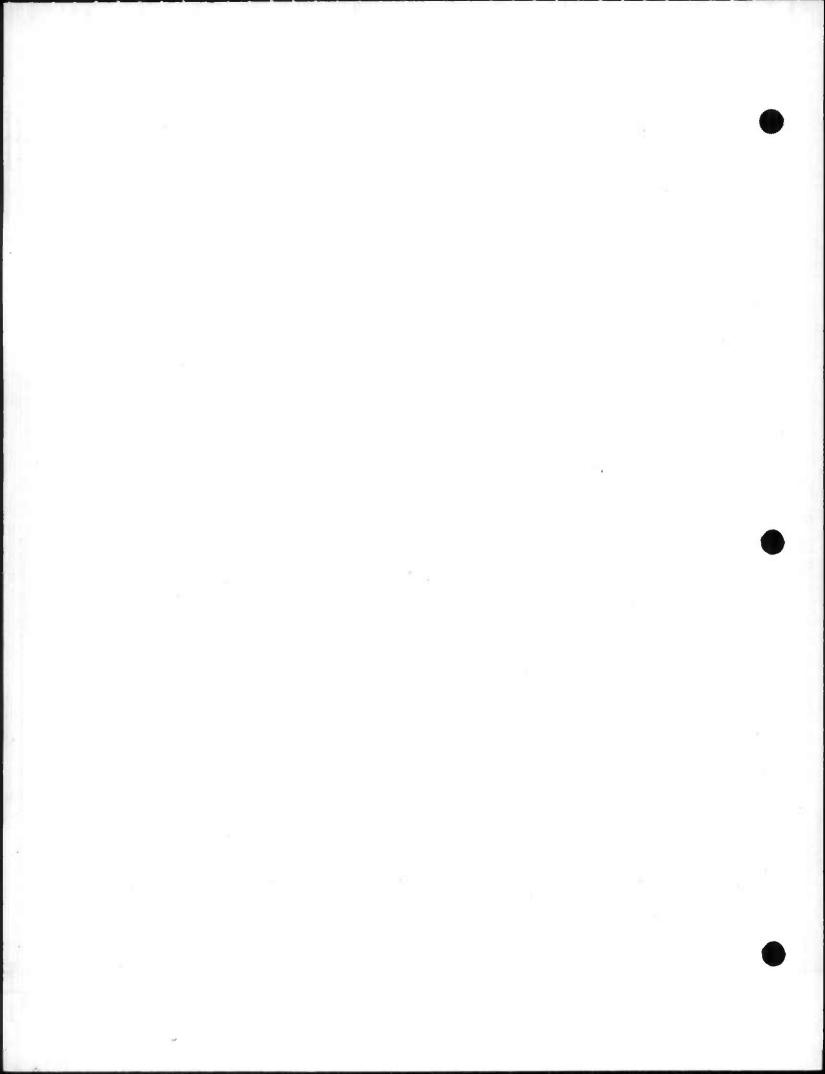
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MONTH DAY YEAR  3. TIME OF DEATH													
	SZANISZLO		The state of the s					3, 1	2:35 Pm					
	4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (In )	rs. lest birthdi	birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF					OF BIRTH 8. BIRTHPLACE (State or Foreign			
	578-54-1923	3 1 X M 2 F 65 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) April 10,								193	Country)			
	Se. FACILITY NAME (If not in		9b. CIT	th. CITY, TOWN OR LOCATION OF DEATH  Bc. COUNTY OF DEATH										
8	3421 Unive	t. 10	2 K	ensi	ngto	n			Mon	tgom	erv			
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY												
E													10d. INSIDE CITY LIMITS?	
	Maryland Montgomery						ngto							1 YES 2 NO
FUNERAL		102		10	1. ZIP COD	895			10g. CITI	ZEN OF WI	HAT COUNTRY?			
빙	3421 University Blvd.West Apt. 102												USA	
	11. MARITAL STATUS  1 □ Never Married 2 □ Married  12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 □ YES 2 ☑ N					If yes, specify Cuban, Mexican, Puerto Rican, etc.)						14, RACE Black,	- American Indian, White, atc.	
ΒY	3 Widowed 4 Divo	rced	IF YES, GIVE V	MR OR DATE	S		1 TYES	2 📉 NO	Specify				Specify	White
		EDENT'S EDUC		16	a. DECEDEN					16b. KI	ND OF BUS	INESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0	highest grade (	College (1-4 or 5 -	,	life. Do NO	of work done use retired.,	during mo	ost of worki	ng					
	8				Cabi	net M	aker			I	nter:	ior I	esig	n
8	17. FATHER'S NAME (First, M.	iddle, Lest)						18. MOT	HER'S NAI	ME (First, Midd	lle, Maiden	Sumame)		
BE	Jozsef Bruc									ingel				
2	19a. INFORMANT'S NAME (7)									loute Number,				20895
	Lory Bruck				342	l Uni	vers	ity 1	Blvd.	West	Apt.	102	Kens	ington MD
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	ovel from State		ACE AND DA								City or Tow	
	4 Donation 5 Other (Specify) Parklawn Cemetery 6/8/95 Rockville, MD													
í	21. SIGNATURE OF FUNEBAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, I										Inc.			
	Il lay	16.	1/11	lell	4					Blvd				
	23. PART I. Enter the di	seasea, or c	omplications tha	t caused th	e deeth. D	not ente	r the mo	de of dy	ing, auch	aa cardiad	or respi	ratory arr	est,	Approximata
	ahock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final												Onset and Death	
	disease or condition resulting in death)	y Fai	lure	-CNS	Fai.	lure					1 Wk.			
			DUE TO	(OR AS A CO	NSEQUENCE	OF):								1
z I	Sequentially list conditions, Metastatic Lung Cancer										2 Yrs.			
ĔI	if any, leading to immed	NSEQUENCE	OF):								/			
CERTIFICATION	cause. Enter UNDERLYI CAUSE (Disease or inju	g Can	UANCET								4 Yrs.			
Ē	that initiated events resulting in deeth) LAS	г	DOE 10	(OH AS A CC	MSEQUENCE	OF):								
8		-												
												WERE AUTOPSY FINDINGS		
MEDICAL											YES 2			AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME														YES 2 NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
5	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  26. PLACE OF DEATH (Check only one)													
Š	1 TYES 2 NO		HOSPITAL:	ER/Outpatie	nt 3 🗆 DOA	4 Nu	R: rsing Hom	6 5 0 R	esidence (	8 Other (S)	pacify)			
PHYSICIAN	27. MANNER OF DEATH	Et III	28a. DATE OF (Month, D		28b. 1	IME OF NJURY	28c. INJ	URY AT	T	28d. DESCRI	BE HOW IN	JURY OCC	URED	
BY		Pending nveatigation				М	-	YES 2	NO					
		Could not be	28e. PLACE O building,	F INJURY atc. (Specify)	At home, farr	n, street, fac	tory, offic	•		281. LOCATIO	ON (Street e.	nd Number	or Rural Ro	ute Number,
E I		determined												
7			CIAN: To the best of											
COMPLETE	one) 2 MEDI	CAL EXAMINER	: On the beels of e	camination an	d/or investig	tion, in my	opinion, d	eath occur	red at the t	lme, date and	place, and	due to the	a ceuse(a)	and manner as stated,
BE O	29b. SIGNATURE AND TITLE	OF CERTIFIER	~1		1 1	-		29c. LICI	ENSE NUM	BER	T	29d. DATE	SIGNED (	Month, Day, Year)
9	Shot	4	Xchu	CO	/ "	rulk	Free	D1	7368			▶ Ju	ine 6	, 1995
F	30. NAME AND ADDRESS OF								11.0.0					4000
	Stanley A.					dical	Par	k Dr	.#201	Sil	ver S	Sprin	ig, M	D 20902-
	JUN 06	1005	REGISTRA	R'S SIGNATO	RE July									
	3011 30	1333	din water		- Colony									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

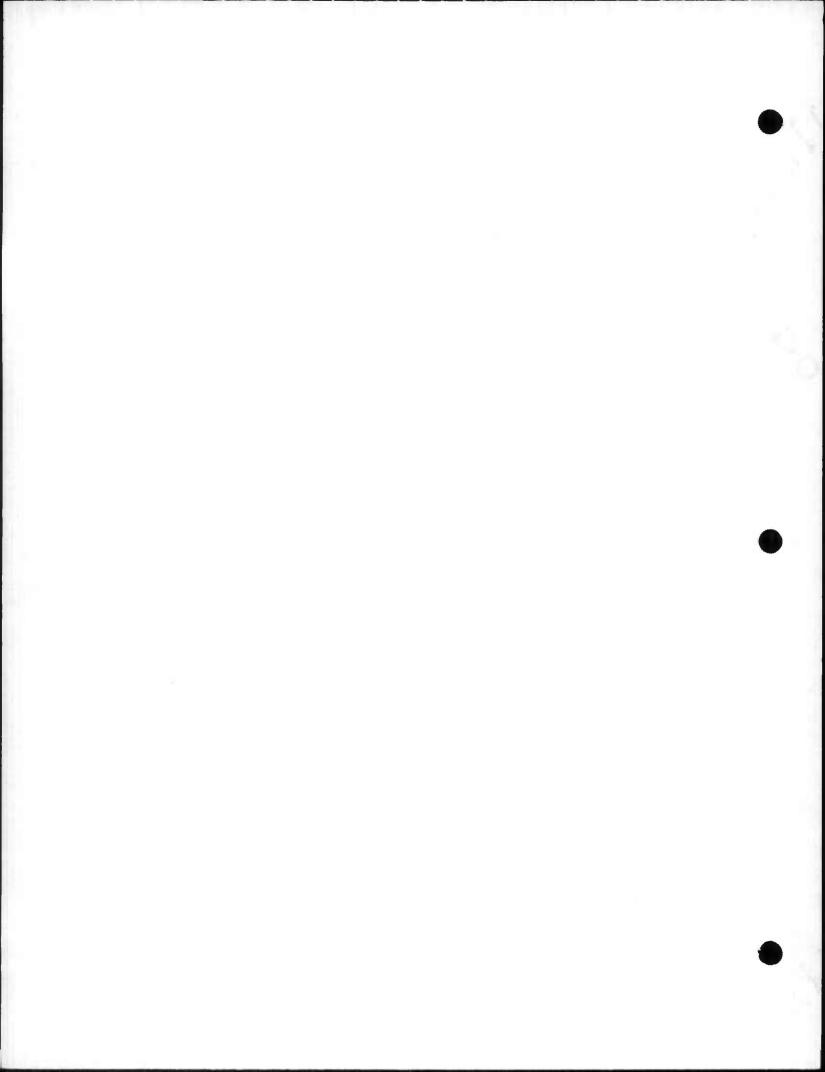
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be netitled at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI			MENTAL	HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)	Raymond T				2. DATE O	OF DEATH	9 <sup>YEAR</sup>	3. TIME OF DEATH 6:35 A			
	F70 /0 00//	0.00			IF UNDER 24 HRS. HOURS MIN.	7. DATE O (Month, Apr.	Day, Year)	Country	PLACE (State or Foreign ) ington, D.C			
TOR	9a. FACILITY NAME (If not institution, give stre 533 Southview Aver RESIDENCE OF DECEMENT				Spring			9c. COUN		EATH		
DIRECTOR	10a. STATE 10b. COUNTY Maryland Montgo	omery		er Spr						10d. INSIDE CITY LIMITS? 1 NO YES 2 NO		
FUNERAL	10e. STREET AND NUMBER 533 Southview Aver	nue			20905			HAT COUNTRY?				
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR I	2 NO	If yes, sp	ENDENT OF HISPA Icify Cuban, Mexic 2 X NO Specia	in, Puerto Ri	(Specify Yes icen, etc.)	or No-	Black,	- American Indian, White, aic.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of worn life. Do NOT use n	k done during mo stired.)	st of working		KIND OF BUS		JSTRY			
COMP	12th 17. FATHER'S NAME (First, Middle, Last)	0	Self-e	mployed	18. MOTHER'S NA	ME (First, Mi		Sumame)	ontr	actor		
TO BE	Raymond T. Balling				Louise	Route Numbe	or, City or Town	n, State, Zip				
	Zetha V. Ballinger  20e. METNOD OF DISPOSITION 1 & Burlal 2 Cremation 3 Remov	20	b. PLACE AND DATE OF	DISPOSITION (Na	me of	OATE	20c. LO	CATION — C	Ity or Tow	yland 20905		
	21. SIGNATURE OF ENNEMAL SERVICE LICENSEE  A Donellon 5 Other (Specify)  A Donellon 5 Other (Spe											
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
١١	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO											
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  A CASE REFERRED TO MEDICAL OTHER:  A CASE REFERRED TO MEDICAL OTHER:											
	1 VES 2 NO 1  27. MANNER OF DEATH  1 No Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	patient 3 DOA 4	28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURE!								
IEU BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. PLACE OF INJUR building, etc. (Spe	f — At home, Jerm, atre- city)	home, Jerm, atreet, factory, office 281. LO					LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLE	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:	AN: To the best of my know								and manner as stated.		
	39b. SIGNATURE AND TITLE OF CENTIFIED  30. NAME AND ADDRESS OF PERSON WHO	an	MP.		D41	828	3	PJU	SIGNED (	Month, Day, Year) 2, 1995		
	31. DATE FILED (Month, Day, Year)	N, M.D.	7525	Green	way (	ente.	r Dr.	Gree	uble	T. H.D.		
	JUN 06 1995	32. REGISTRAN'S SIGN	Rardall		J							



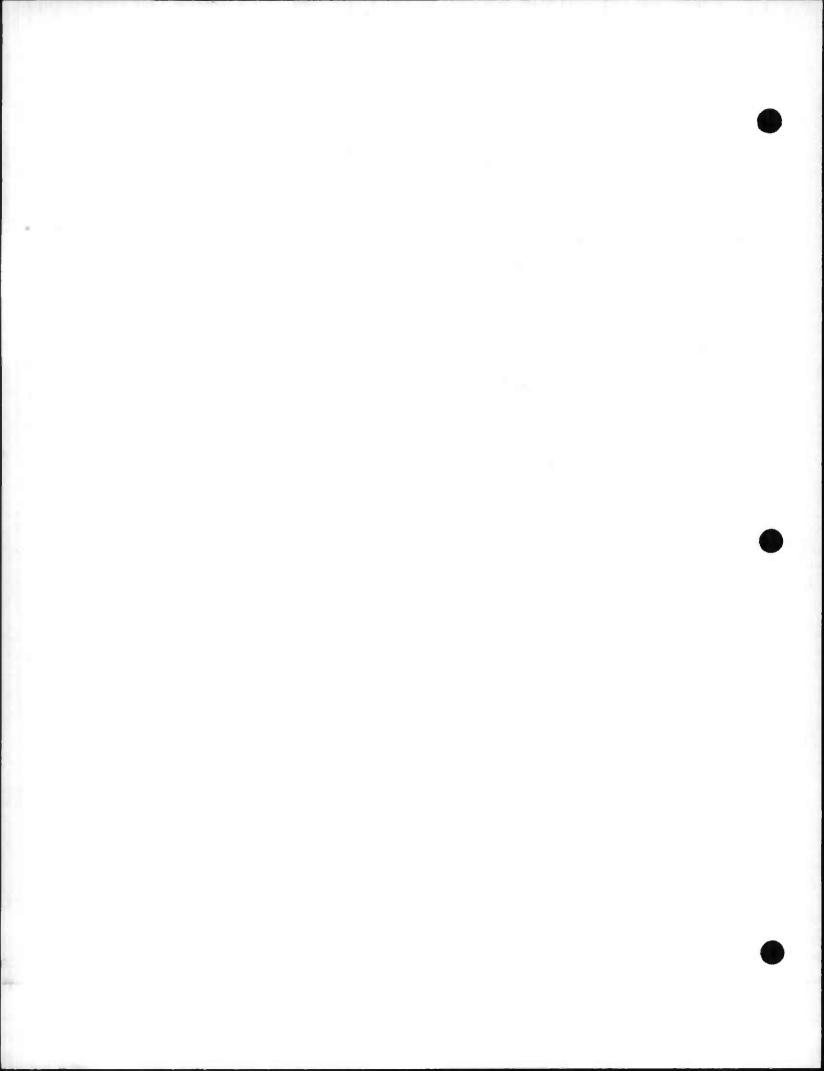
באפוווווים וונחפר מה ווסווויהם פו חווכם.	THE CHICAGO IN THE STATE OF THE PARTY OF THE
al. examiner must be notified at once.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
re funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp

30. NAME AND ADDRESS OF PERSON OF THE MONTH (1995)
31. DATE FILED (Month, Day, Voat)

JUN 1 2 1995

12. negythars siangyme

												95		0 9 3 0
	FOR STATE REGISTRAR		STATE OF N	IARYLAND /	DEPAR ERTIF	RTMEN	T OF H	EALTH DEAT	AND I	MENTA	L HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First,		***************************************	777						MONT	OF DEATH	la.	YEAR	3. TIME OF DEATH
		harles								June	9,	199	5 YEAR	7:35 AM M
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDE	DAYS	# UNDER	24 HRS.	7 DATE OF BIRTH			Country	PLACE (State or Foreign
	212-14-9531 12 № 2 □ 1 80							Noons	willy.	Feb. 9, 1915 V				rginia
~	9a. FACILITY NAME (If not institution, give street and number)					9b. CIT	Y, TOWN C	R LOCATIO				9c. COUR	NTY OF DE	
5	3741 Aldino							Abe	rde	en			Ha	rford
DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10d, INSIDE CITY	
5	Maryland		Harford					P	berd	deen				LIMITS?
FUNERAL	10e. STREET AND NUMBER						101	ZIP CODE				10g. CITI	ZEN OF WI	HAT COUNTRY?
띮	37	41 Ald	ino Road		21001						11	U	SA	
5	11. MARITAL STATUS		12. WAS DECEDEN	TEVER IN U.S. AR		13.	WAS DEC	ENDENT O	F HISPAN	SPANIC ORIGIN? (Specify Yes or No-				- American Indian, White, etc.
84	1 Never Married 2 🔀		IF YES GIVE W	AR OR DATES	If yes, specify Cuben, Mexic 1 ☐ YES 2 🔀 NO Spec								Specify	
		EOENT'S EDUC				1								white
	(Specify only	highest grade	completed)	(G	CEOENT'S ive kind of a Do NOT us	work done	during mos		g	16b	16b. KINO OF BUSINESS/INDUSTRY			
7	Elementary/Secondary (0-	-12)	College (1-4 or 5 +	)	alve			n			Chemi	cal	Como:	anv
COMPLETED	17. FATHER'S NAME (First, Mit	ddle, Last)		***	18. MOTHER'S NA					ME (First, I			Compo	Arry
BE C	William	Wagg	Blevins								ctoria		er	
	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
10	Viola J. Blevins 3741 Aldino Road, Aberdeen, Maryland 21001												21001	
	20a. METHOD OF DISPOSITION 1 (28 Burle) 2 Cremation	ON Bemo	val from State	20b. PLACE	AND DATE	OF DISPO	SITION /Na	me of		OAT	E 20c. LO	CATION	City or Tow	n, State
	4 Donation 5 Other (Specify) Maryland Memorial Gardens 6/13/95 Aldino, Maryland													
	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009											me, P.A.		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest,  Approximate													
	IMMEDIATE CAUSE (Fine disease or condition			10	11/	AC	•				Onset and Death			
	Peaulting in death)  e											20 yrs		
Z	disease or condition reaulting in death)  • CARCINUMA (UNAS)  Due to (or as a consequence of):  Emplifs Emp												20415	
CERTIFICATION	Sequentially list condition if any, leading to immed	liata	NSEQUENCE OF):											
5	CAUSE (Disease or injury  CAUSE (Disease or injury  DUE TO (OR AS A CONSEQUENCE OF)													
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
ら!	d.													
	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
Š	Corona	RY	ORT1	924	DC	50	of c				PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ᇦ		' /								_	/	6.00		OF BEATH?
ä	DID TOBACCO US	SE CONTR	IBUTE TO CA	JSE OF DEA	TH YE	SZ	NO 🗆	UNC	ERTAIN					
N.	25. WAS CASE REFERRED TO EXAMINER?				E OF DEAT									
S	1 TYES 2 XNO		HOSPITAL:	ER/Outpetient 3	□ DOA	OTHE 4 Nu	R: sing Home	5 Ra	sidence	8 🗆 Othe	r (Specify)			
PHYSICIAN: MEDICAL	27. MANNER OF DEATH		26a. DATE OF (Month, Da		28b. TIM	E OF URY	28c. INJU			28d. DES	CRIBE HOW IN	JURY OCC	URED	
B		Pending nvestigation	2017			М	1 🗌 Y	ES 2 [	NO					
THE RES		Could not be letermined	28a. PLACE Of building,	FINJURY — At home. (Specify)	me, farm, s	street, fac	tory, office				ATION (Street a or Town, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	29a. CERTIFIER 1 CERTI	FYING PHYSIC	IAN: To the best of	my knowledne de	ath occur	ed at the	lme deta	and elec-	and 4.:	to the ex	na(a) a= 1 =			
M M														and manner as stated.
N N	SIGNATURE AND TITLE		/						NSE NUM					Menth, Day, Year)
00	Hantiu.	nun	of Inv	0				111-	1/	61		▶ //	101	01
2	30 NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	F OF OFATH (ITEM	4 27) /Time	Print		19)	WY	4		4	111	73



95 18951

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 11,1995 JUNE P M 2000 CHARLES BURTON JR. ALFRED 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1XXM 2 | F 213-82-1734 Dec. 19, 1960 Virginia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number. 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH ROUTE#159 DIRECTOR HARFORD Perryman RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford 1 YES 2 X NO permit. Aberdeen FUNERAL 10f. ZIP COOE 10g. CITIZEN OF WNAT COUNTRY? use as the burial-transit 1821 Park Beach Drive 21001 U.S.A. ay be retained by the hospital or attending physician. page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— tf yea, specify Cuban, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: В 3 Widowed 4 Divorced 1979-1984 White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12 Laborer Concrete pipe Manufacturing 17. FATNER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Alfred Burton, Sr. Mary Ann Milam notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mr. Charles A. Burton, Sr. 5304 Ruth Moois Road, Wilauma, Florida 33598 hours after death. Page 6 may be pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must funeral director, Gardens of Faith Cemetery 6/14 Parkville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 filled in by the traumatic event, the medical 23. PART I. Enter the deeses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 0 interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) injuries ysician and completely prior to burial, crematic Head BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST DIVISION OF VITAL RECORDS, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 19 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate to the State EXAMINER? HOSPITAL: 1 Inpatiant 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 X Other (Specify) ROADWAY 27. MANNER OF DEATN 28b. TIME OF INJURY 18 SS M 28a. DATE OF thJURY 26c. INJURY AT WORK? marked, 28d. OESCRIBE HOW INJURY OCCURED this c 1 Natural 6-11-95 5 Pending BY 1 YES 2 PNO Kred object cousin After 2 Accident
3 Suicida 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 261, LOCATION (Street and Number or Rural Route Number 28 18 COMPLETED 8 Could not be THE FUNERAL DIRECTOR; filed within 72 hours after 4 Nomicide determined oadwar Item 2 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL (TO THE FUNERAL DE FILE WITHIN 72 M HOSPITAL. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND THE OF CENTER 29d. DATE SIGNED (Month, Day, Year)

JUNE 12, 1995 BE 29c. LICENSE NUMBER O.C.M.E 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Powler

02. REGISTRAN'S SIGNATURE

JUN 1 3 1995

111 Penn Street, Baltimore, Maryland 21201

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

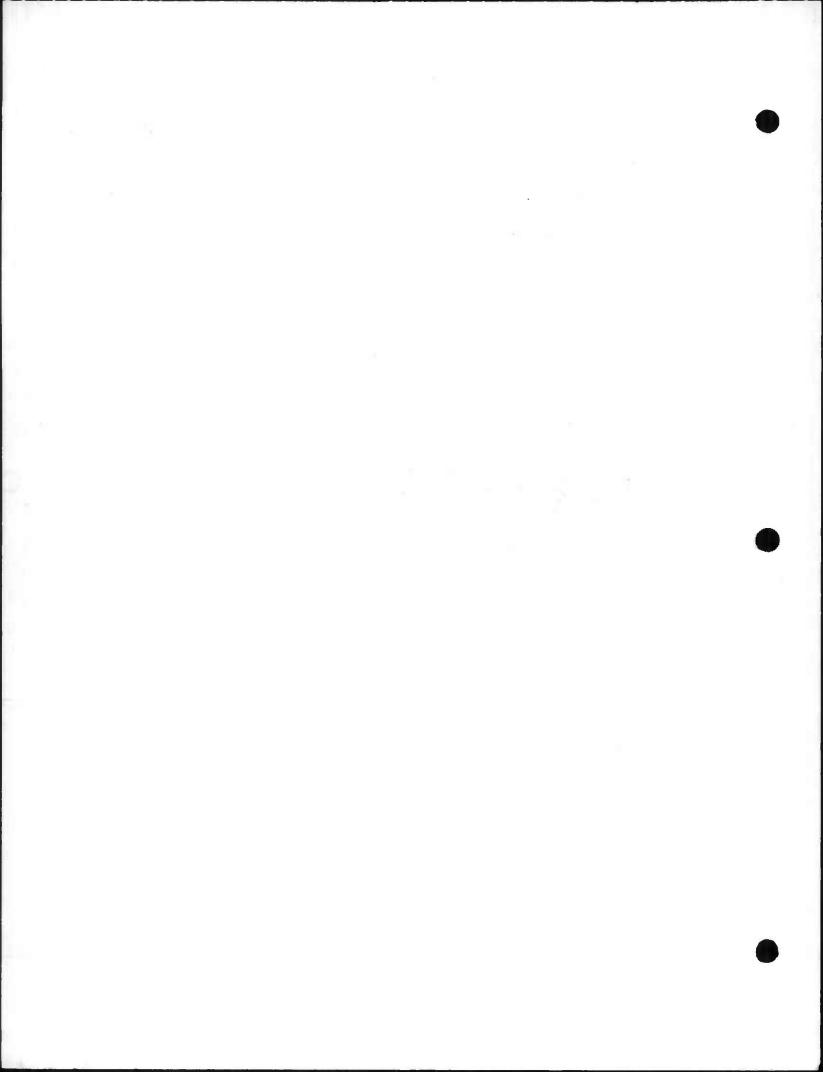
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

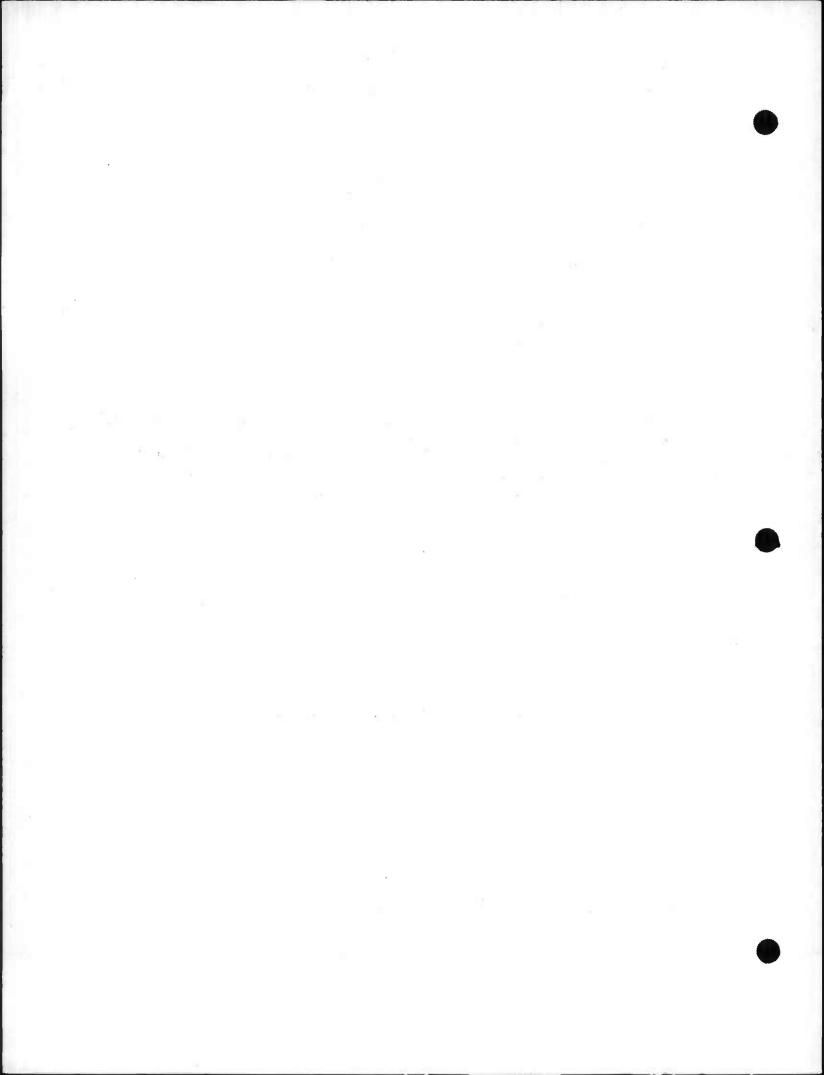
1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH  3. TIME OF DEATH										3. TIME OF DEATH				
	EVA	MAE	BROWN						JUNE	5 <sup>M</sup>	19	95 <sup>YEAR</sup>	02:55 A M	
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDE	R 1 YEAR	IF UNDER	1 24 HRS.	7 DATE OF I	BURTH		8. BIRTH	IPLACE (State or Foreign
	217-40-7585	5	1 □ M 2 □ F	78	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct.	7. Year)	116	Countr	"Virginia
	9a. FACILITY NAME (If not in	nstitution, give s	reet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							45	
S	Sacred Hea	rt Hos	nital			Cumberland Allegany							inv	
DIRECTOR	Sacred Hea					Cuidel faild 111							110,50	
끮	10a. STATE	10b. COUNTY				Y, TOWN		CATION						10d. INSIDE CITY
	Maryland		gany		Mic	:Coo	1e							1 YES 2 NO
₹	135 West S				101. ZIP CODE							10g. Cf1	TIZEN OF V	VHAT COUNTRY?
FUNERAL		ot.			21562							U		
교	11. MARITAL STATUS  1 Never Married 2	Merried		YES 2 V	NO If yes, specify Cuben, Mexican, Pr						pecify Yes n, etc.)	— American Indian, c, White, atc.		
À	3 🔀 Widowed 4 🗀 Dive		IF YES, GIVE V	AR OR DATES			1 🗌 Y	ES 3 X NO	Specify	y:			Speci	
		EDENT'S EDUC		16a, C	DECEDENT'S	USUAL C	OCCUPA	TION		16b KIN	D OF BUS	INESS/IN	DUSTOV	White
	(Specify onl	y highest grade	College (1-4 or 5		(Give kind of a life. Do NOT us	vork done	during i		ng	1000	0. 000		0001111	
뢰	Unknown			'   _	Home	make	er				Home			
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)	<del>.:</del> -		18. MOTHER'S NAME (First, Middle, Maid						e, Maiden	Surname)		
BE	Harrison	B. Dy	e					Н	leste	er McMa	nus			
9	19a. INFORMANT'S NAME (1	ype/Print)		- 1	19b. MAILING	ADDRES	S (Stree	t and Number	or Rural I	Route Number, C	Olty or Town	n, State, Zi	p Code)	
Ĕ	Roger Gu	inn			135	West	St	. M	icCoc	ole, Mo	1. 21	562		
	20a, METHOD OF DISPOSIT 1 ☐ Burlet 2 ☐ Cremetic	ION	wal from State	20b. PLAC	E AND DATE	OF DISPO	SITION	Nama of		DATE	20c. LO	CATION -	City or To	wn, Stata
ı	4 Donaflon 5 Other	oming	ton	Cem	etery	6-	8-95	Blo	omin	gton	, Md.			
	21. SIGNATURE OF FUNERA	Boal Funeral												
	14/1	/11	AR/	Sink								nnor	+ M	d. 21562
	23. PART I. Enter tha d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart tallure.	Liet Drily Dria cau	STATI C	- CA	RCIA					Dr reapi	atory ar	Tout,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list condition, large l	diata ING iry	<u> </u>		ONSEQUENCE OF):									
- 11	PART ii. Other significa							ing cause (	givan in	Part I. 24a	. WAS AN		246.	WERE AUTOPSY FINDINGS
EDICAL	CHRUNI	L US	5RUCTU	e Lun	UC D1	SEA	SE				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
	ORBANIC	AFFE	CTIVE	BISURDE	R SE	rui	RE 1	SISUR	DER	_   ' '	100 1	M IIIO		OF DEATH?
	DID TOBACCO U									10				
SICIAN	25. WAS CASE REFERRED TO EXAMINER?				ACE DF DEAT									
2	1 TYES 2 PNO		HOSPITAL:	ER/Outpatient	3 DOA	OTHE		ome 5 🗆 Ra	aldence	s Other (Sp.	ecity)			
ВУ РНУ		Pending Investigation	28a. DATE OF (Month, D		28b, TIM	E OF URY M	V	NJURY AT VORK? YES 2	] NO	28d. DESCRIE	BE HOW IN	JURY OC	CURED	
3	3 Suicide s Homicide	home, ferm, s	treet, fac	tory, off	fica		28f. LOCATIO	N (Street a wn, State)	nd Numbe	r or Rural R	loute Number,			
COMPLEI							to the cause(s							
3			C On the beats of a	camination and/o	r investigatio	n, In my o	opinion,	death occur	ed at the	time, data and	place, and	dua to t	he cause(s	) and manner as stated.
4	29b. SIGNATURE AND TITLE	OF CERTIFIER	0					1	NSE NUN	IBER	29d. DATE SIGNED (Month, Day, Year)			
2	00 11415 117 157	<u> </u>	Seeller					1 2 2	690	7			INE S	1995
	51 dhu Ha	wit.	MD 92	5 Bis	hop U	Print)	sh	Roac	16	umber	land	1.1	10 2	21502
	31. DATE FILED (Month, Day, JUN 07	*		R'S SIGNATURE	lath							,		



BALTIMORE. MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

		REGISTRAR		CERTIF	ICATE C	F DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	t-	Dlabaa	1-		2. DATE OF DEATH DON'TH D	AY YE	AR 3. TIME OF DEATH
		Helen Elizab		Blubau (In yrs. last birthday)	IF UNDER 1 YEA	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	1995	BIRTHPLACE (State or Foreign
_		212-24-0162	1 □ M 2 😾 F	75 YRS.	MONTHS DAY		eb. 27, 1920	) Ma	country)
plnods		9a. FACILITY NAME (If not institution, give a	·		9b. CITY, TOV	VN OR LOCATION OF DE		9c. COUNTY	4
. 2. 3	DIRECTOR	15119 New George	es Creek Rd,	S.W.	Frostb	urg		Alleg	any
iges 1	REC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION			10d, INSIDE CITY
it. Pa		Maryland Alleg	any	Fros	tburg				1 YES 2 NO
physician. purial-transit permit. Pages 1, 2, 3 should	FUNERAL	15119 New Georges	Creek Rd, S	S.W.		101. ZIP CODE 21532		USA	OF WHAT COUNTRY?
ding physician.	ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes	DECENDENT OF HISPAN, specify Cuban, Maxica YES 2 NO Specify			RACE — American Indian, Black, Whita, etc. Specify: White
attending use as the	TED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	work done during	ATION most of working	16b. KIND OF BU	SINESS/INDUST	RY
spital or atte	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homema	se retired.)		Home	9	
by the hospital d be detached fo	ш	17. FATHER'S NAME (First, Middle, Last)  John Henry Clis	se .			18. MOTHER'S NA Tinie	ME (First, Middle, Melden Elizab	Sumame) eth B	eeman
be retained ge 5 should re notified	TO B	194. INFORMANT'S NAME (Type/Print) Helen P. Kenner					Route Number, City or Tow V., Frostbur		
e 6 may ector, pa must b		20a. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from Stata 20b	b. PLACE AND DATE of the terry, cremetory or o	of Disposition ther place)	al Park	5,1995 Fre	cation - city ostburg	or Town, State , Maryland
death. Page funeral dire 		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	uscourg	Eich	ANO ADDRESS OF FA	zie Funera	al Home	
0 - 0	J.	you E. M	likes			coning,Md.			
ted within hours after completely filled in by th ial, cremation, or remove event, the medical		IMMEDIATE CAUSE (Final	List only one ceuse on e	each lina.	1	- 11	-1/1/1		Interval Batween Onest and Dasth
xecuted wand comp burial, ci	z		ARTERIL	SCL EN	OTIC	CARDIO	JASC 41	AO DIS	the salt
be eccian a lor to	CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	A CONSEQUENCE OF	F):				V - H
death certificate attending physiental Hygiene pri	띮	CAUSE (Disease or injury that initiated events	Ç	A CONSEQUENCE OF					
	ERT	resulting in death) LAST	d						
e 로돌 클		PART II. Other significent condition	s contributing to deeth b	but not resulting	In the underl	ying ceuse given in	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS
that the red by the and the and the	EDICAL	V.				- N	PERFOI		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires the been signed t. of Health a shows any	ME						<u>_</u> _/		1 YES 2 NO
23 ep	Ä.	DID TOBACCO USE C	CONTRIBUTE TO	CAUSE OF		YES   NO			
N: The ficate h State E	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		OTHER:	S. PLACE OF DEATH (Ch			
SICIAN: The certificate in the State	PHYS	27. MANNER OF OEATH	1 Inpatient 2 ER/Outs 26a. DATE OF INJURY	28b. TiM	E OF 28c.	NJURY AT	6 Other (Specify) 28d. OESCRIBE HOW I	NJURY OCCURE	ED .
DING PHYS After this of death with s marked	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1	WORK?			
TTENDI TTOR: A after da		3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, etc. (Spec	Y — At home, farm, acify)	street, factory, o	offica	26f, LOCATION (Street City or Town, State)		ural Route Number,
AL DR A L DIREC 2 hours I flem	COMPLETE		ICIAN: To the best of my know	viedge, deeth occurr	ed et the time,	deta and place, and due	to the cause(s) and me	nner as stated.	
HOSPITAL FUNERAL WITHIN 72 I	SOM	one) 2 MEDICAL EXAMINE	R: On the basis of examination	on and/or investigation	n, in my opinio	n, death occured at the	time, data and place, ar	nd due to the ce	use(a) and menner as stated.
TO THE HOSPIT TO THE FUNER be filed within 7	BE	296. SIGNATURE AND TITLE OF CERTIFIER	R N	0100	1.71	29c. LICENSE NUM	ABER )	29d. DATE SIG	BNEO (Month, Day, Year)
268	5	30. NAME AND AGGRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)	0) 0.	AVDIC	165	45
}		31. DATE FILED (Moptly, Day, Yan)	ハイメーを代し	IN	1)	127 9 8	161 20	Camb	CHARA MY
	4	JUN 0 5"1995	S2 REGISTRAN'S SIGN	Hardall					



STATE REGISTRAR

JUN 05 1995

1 -

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WAYNE KEVIN MAY 30 2:30 P.M BROOKMAN 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year B. BIRTNPLACE (State or Foreign DAYS HOURS 1×XM 2 | 1 MIN. 220 48 6626 37 YRS. 28. May 1958 Maryland Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 4742-A FLANDERS LANE ANNE ARUNDEL HARWOOD 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Harwood permit. 1 YES 2 XX0 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10c. CITIZEN OF WHAT COUNTRY? 4742-A Flanders Lane be detached for use as the burial-transit 20776 United States Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2/12 NO Specify: 1 Never Married 2 X Married BY 3 Widowed 4 Divorced Specify: No White 60 15. DECEDENT'S EDUCATION pecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spi COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Park Maintenance Leader State of Maryland 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) 10 James Brookman BE Florence Jean Arnold funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Laurie Brookman 4742-A Flanders Lane Harwood Maryland 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremetton 3 Removal from State
4 Donatton 5 Removal from State å 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cemetery, cremetory or other piece)
Lakemont Memorial Gardens 6/3/95 Davidsonville Md. ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. Robert E. Evans Funeral Home, P.A. obert 16000 Annapolis Rd. Bowie Md. 20715 completely filled in by the hours after medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such se cardiec or reapiratory erreat, Approximate shock, or heart failure. List Interval Betwe ation, or **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition 019 0 event, reaulting in death) crem DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): hysician and com executed traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to the death certificate be e. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t Health and requires that any YES 2 NO OF DEATH? YES 2 NO L of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN; The law has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL OTHER: 1 X YES 2 - NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 X Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 280. DATE OF INJURY TIME OF 26c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, PLACE OF INJURY — building, atc. (Specify) this 1 Natural M 1 YES After t BY 2 Accident 281. LOCATION (Str. 3 Suicide
Nomicide At home, farm, straet, factory, offica 99 ETED 6 Could not be DIRECTOR: 28 determined Hone COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) (Check only PUNERAL within 72 h H)SPITAL = TO THE HUSPITA TO THE FUNERA DE filed within 72 MEDICAL EXAMINER: On of axamination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. MAY 31,1995 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 DATE FILED (Month, Day. 32. REGISTRAPIS SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

 1. DECEDENT'S NAME (First, Middle, Last)

Ε.

BROWN

5. SEX

CARRIE

4. SOCIAL SECURITY NUMBER

FOR STATE REGISTRAR

25,1995

3. TIME OF DEATH

P

3:30

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

YES 2 NO

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

COMPLETION OF CAUSE

YES 2 NO

Interval Between

**Onset and Death** 

8. BIRTHPLACE (State or Foreign

Washington

2. DATE OF DEATH

7. DATE OF BIRTH

MAY

IF UNDER 24 HRS.

retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 Page 6 may be hours after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760

535-80-4472 18 Apr. 18, 1977 1 M 2 XF YRS. permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION Prince George's Maryland Bowie FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. 14018 Westview Forest Drive 20720 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Xiver Married 2 Merried If yes, specify Cuban, Mexican, P 1 TES 2 NO BY 3 Widowed 4 Divorced Specify: No COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Student School once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Darrell Brown Barbara Musolf notified at BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Darrell Brown Same as #10. pe 20s. METHOD OF DISPOSITION
1 State 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must tery, cramatory or other place)
• Oak Cemetery Mt. 5/30 Mitchellville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Robert E. Evans Funeral Home, P.A. 16000 Annapolis Road Bowie, MD 20715 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the 1 withy disease or condition morels resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior to If any, leeding to immediate requires that the death certificate be cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by t Health and any 1 YES 2 - NO Shows this certificate has been with the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Hem HOSPITAL:
1 | Inpetient 2 Pr/Outpetient 3 | DOA L DIRECTOR: After this certificate 2 hours after death with the State OTHER XXYES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Natural
2 Accident
3 Suicide 1030 Q-M 1 YES BY Investigation 28e. PLACE OF INJURY — At home, term, building, stc. (Specify) 90 COMPLETED 8 Could not be 4 Homicide violwa 28 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and marrier to state of FUNERAL I = HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and piece, and due to the cause(s) and IMPORTANT: 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 五五百 B new) O.C.M.E 2 2.1 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TEVIDORE KINP Mi PENN STREET BALTIMORE, MARYLAND 111 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Staveleor Ran

UD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

6. AGE (In yrs. last birthday)

DHMH-18 Rev 1/89

21201

MAY 26,1995

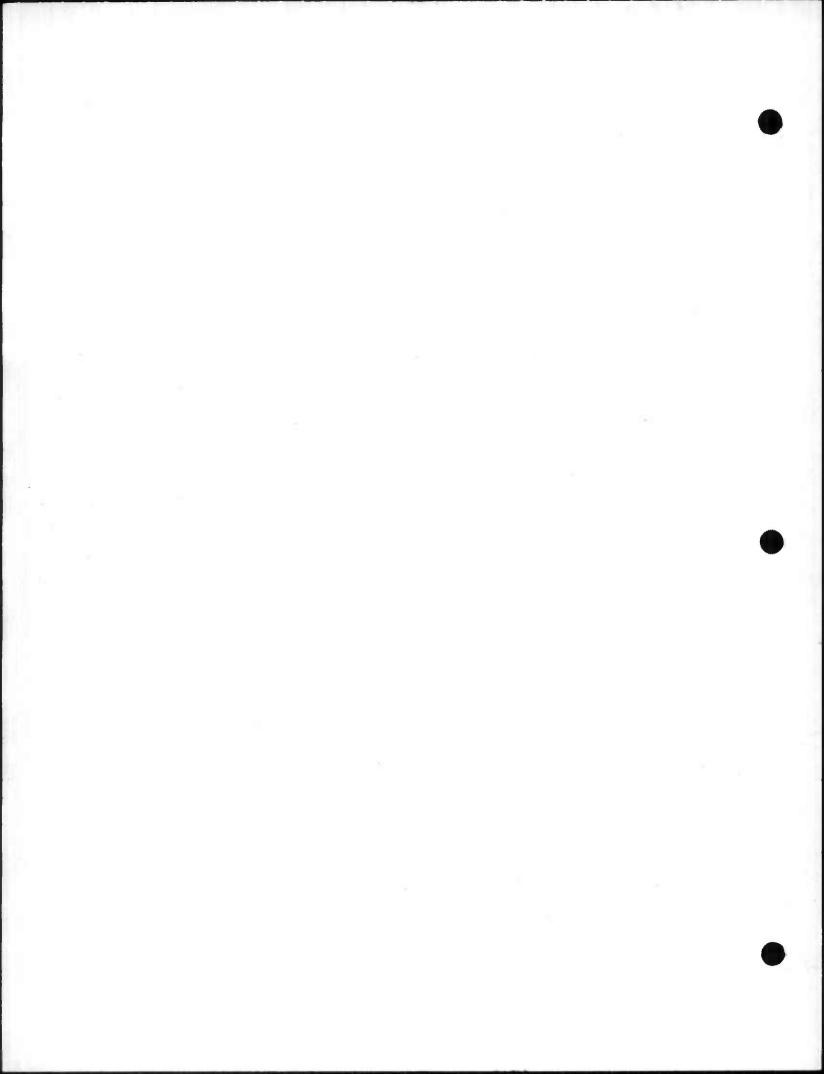
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIFFCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, chemation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	t, Middle, Last)			2						DEATN	3. TIME OF OEATN		
	Carlist	o His	nins	RI ANCHA	ກກ					MONTH	01		YEAR	
	4. SOCIAL SECURITY NUMBER	BER TILL	5. SEX	6. AGE (In yrs. I		IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTN	2	8. BIRTI	S: 12P M
	579-20-5358		1 📉 M 2 🗌 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	March		1923	Count	nington, DC
	9s. FACILITY NAME (If not in		treet and number)	72		9b. CIT	r, TOWN	OR LOCAT	ON OF DE		10,		INTY OF D	
8	Doctor's C	ommuni	ty Hospi	tal		La	nhan	1				Pri	nce	George ts
ַל	RESIDENCE OF DEC	10b. COUNT			T-10 - 0.11									
DIRECTOR				t _		Y, TOWN								10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER		e George	S	Ну	atts						40 - 017		1 TYES 2 NO
A.	6116 42nd P			101. ZIP CODE 20781							1.52 (38):150			
FUNERAL	11. MARITAL STATUS	Tace	12. WAS DECEDEN	IT EVER IN U.S. A	ARMED	13	WAS DEC			IIC OBIGINS (S	United C ORIGIN? (Specify Yes or No.—   14. RAC			E - American Indian,
	1 Never Married 2 🔀		FORCES? 1	YES 2 X	NO		If yes, sp	ecify Cubi	n, Mexica Specify	n, Puerto Rice	n, etc.)		Biac	k, White, etc.
) BY	3 Wildowed 4 Divo	orced											4,000	White
TED	15. DEC (Specify onl	EDENT'S EDU ly highest grade	CATION completed)		(Give kind of work done during most of working 1					16b. KII	D OF BUS	INESS/IN	DUSTRY	
COMPLET	Elementary/Secondary (0	0-12)	College (1-4 or 5	+)	fe. Do NOT u	,					4 7 4 .			
W.	17. FATHER'S NAME (First, M	firirita Lasti			leric	al					ilit	-	Comp	any
	Ellery C. B	, ,	rd							ME (First, Midd		,		
<b>BE</b>	19a. INFORMANT'S NAME (		Lu		9b. MAILING	ADDRES	S (Street a			et Hig			n Codel	
2	Deborah V.	Lilly	. 5							ne, Ch				20733
20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rarboval from State 20b. PLACE AND DATE OF DISPOSITION commetery, cremetery or other place)									L. Lica	DATE			City or To	
	4 Donation 5 D Other	(Specify)		Font	Linc	ther place) 01n	Ceme	tery	6/	9/95	Bre	ntwo	od,	Maryland
	21. SIGNATURE OF FUNERA	L SERVICE LA	ENSEE	//					SS OF FA		1 11-		T	
	<b>•</b>	X	1	M						Funera				, MD 20722
	23. PART I. Enter the d	90000S, 01	complications the	t caused the	leath. Do	not enter	the mo	de of dy	ing, suci	h aa cardiac	or reapi	ratory ar	rest,	Approximate
	ahock, or h iMMEDIATE CAUSE (Fir	eart fallure.	List only one cau	ise on each lir	1e.		Ų							intarval Between Onset and Death
	disease or condition resulting in death)	<b>→</b>	. Uc	uti	Re	n	l.	ta	lu	re				1111
1			QUE TO	(OR AS A CONS	EOUENCE O	F):		-						, and
No.	Sequentially list condit	lona.	Phyl	ouse	am	amia								1/2cok
CERTIFICATION	if any, leading to imme- cause. Enter UNDERLY	diate	Despio	(OR AS A CONS	EOUENCE O	2		Failure 114.					1	
윤	CAUSE (Disease or inju- that initiated events		DUE 30	OR AS A CONS	EQUENCE O	Y La	~		2	~~~	~	-		Mo
E	resulting in death) LAS	T (	Cent		erne	un 1	hea	-	29	D-C				74R
	PART ii. Other algnifica	nt condition	e contribution to	death but not		la sha	ad a abata						-	1/
EDICAL	Ragar	*	a continuouing to	Geath but not	resulting	in the ui	idenyini	cause	given in	Part I. 24	PERFOR		246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
	Can an		My	in,	The	4/7		ممل		1	YES 2	DINO		OF DEATN?
Σ	DID TOBACCO U	SE CONTI	PRIITE TO CA	LISE OF DE	ATLI VI	:c [7]	NO F	LINK	EDTAIN					1 TYES 2 NO
NA N	25. WAS CASE REFERRED TO		YDOYL TO CA		CE OF DEA			DIAC	EKIAII	<u>ч                                    </u>				
PHYSICIAN:	EXAMINER?		HOSPITAL:			OTHE	R:	5 🗆 9	reidence	8 Other (Sp	andha)			
Ě	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIN	E OF	28c. INJ	URY AT		28d. DESCRI		JURY OC	CURED	
8Y F		Pending Investigation	(Month, D	dy, rear)	IN.	IURY M		RK7 (ES 2 [	NO					
0	3 Suicide 8	F INJURY — At I	nome, farm,	street, fac	tory, offic			28f. LOCATIO	N (Street a	nd Number	r or Rural F	Route Number,		
	4 Homicide						Oily or no	wri, oteley						
COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.													
O.	2 MEDI	ICAL EKAMINE	R; On the basis of e	xamination end/o	r investigatio	on, in my o	opinion, d	eath occur	red at the	time, date and	place, and	d due to fi	he cause(a	) and manner as stated.
BE (	296. SIGNATURE AND TITLE	OF BESTIFIES						29c. LIC	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
10 B	( out	n	un		20			00	987	4		•	6-0	-95
-	DE NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	31. DATE FILED (Month, Day,	TRMAN Year)	32 DECISTO	R'S SIGNATURE	KEN	ilv	nt	_ a_	u	Keve	rol	sh	n	N.
	JUN 0 5 199	Years .	A 'A	A SIGNALUHE										
	0011 00 139	3 /	Wal difference	Tarkett.										DMMN 16 9 170



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

	REGISTRAR		CERTIF	ICALE	OF D	EATH	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH			
	ELLEN	D	BR	ODE			JUNE 8	1995	00:25 M			
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1		F UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign			
1)	217-10-7924	1 M 2 F	96 YRS.	MONTHS	DAYS H	OURS MIN.	May 14, 1	899 Court	aryland			
1)	9a. FACILITY NAME (If not institution, give str	reet and number)		9b. CITY,	TOWN OR L	OCATION OF DE		9c. COUNTY OF				
HC HC	Sacred Heart Hos	pital		0	ופלווול	rland	_	۸٦٦	egany			
5	RESIDENCE OF DECEDENT					- 2.02.10.		Part	egarry			
끮	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR	LOCATION				10d. INSIDE CITY LIMITS?			
ā	Maryland .	Allegany			Fr	rostbur	g		1 X YES 2 NO			
A	10e. STREET AND NUMBER				10f. ZII	P CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL DIRECTOR	160 Frost Ave	nue				21532		U.S	. A.			
5	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 7	R IN U.S. ARMED	13. W	AS DECENO	DENT OF HISPAN	HC ORIGIN? (Specify Yes	or No- 14, BAC	E — American Indian, k, White, etc.			
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OF		1	YES 24	y Cuban, Mexica:  NO Specify	n, Puerto Rican, etc.)	Spec				
	3 121 Wildowed 4 Divorced				- 2				White			
画	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S	USUAL OCC	CUPATION	l working	16b. KIND OF BUS	INESS/INDUSTRY				
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	se retired.)		· · · · · · · · · · · · · · · · · · ·						
M M	12	2	N	urse			Nur	sing Hom	e			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18	. MOTNER'S NA	ME (First, Middle, Maiden :	Sumame)				
BE	Francis		Davies		. 1	Eliza	beth	Re	Reese			
6	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (	Street and I	Number or Rural F	Soute Number, City or Town	, State, Zip Code)				
	Olin Brode		10604	Lamb	eth F	Road Gl	en Allen V	irginia	23060			
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramo		20b. PLACE AND DATE	OF DISPOSIT			DATE 20c. LOC					
	4 Donation 5 Other (Specify)	wai from State	Fog. Memo	rial	Park	June	10, 95 Fro	stburg.	Marvland			
	21. SIGNATURE OF FUNERAL SERVICE LICI	INSEE	/			DORESS OF FAC	hat effect	Funeral				
- 1	John 1	Muri	_		77 100	TALL ALL TO						
	/0/	nuces		57 Frost Avenue Frostburg, Md. the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,								
	ahock, or heart fellure. L	let only one cause or	each line.	not anter ti	na mode	of dying, such	n as cardiac or reapir	atory arrest,	Approximate Interval Between			
	Onest and Dook											
i	resulting in death)	Oug estive heart Forhere with Pulmay 3 days OUE TO (OR AS A CONSEQUENCE OF): Avlino 8 destric heart Discase Edwa (Inknown										
		DUE TO (OR À	A CONSEQUENCE O	F):	. (	PDu	210					
Z	Sequentially list conditions,				e k	reart	Disca	20	Unknown			
CERTIFICATION	If any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	F):								
2	CAUSE (Disease or Injury											
#1	that initieted eventa resulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE O	F):								
E	d d											
	PART II, Other algnificent conditions	contributing to death	but not regulting	In the unde	erivina ce	use alven in i	Part I. 24e, WAS AN	umpey 24h	WERE AUTOPSY FINDINGS			
EDICAL		timed Dele				ced a	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
	Deg guert		- 0	-		<del>□</del>	1 U YES 2	NO	OF DEATH?			
Σ			lis .		/				1 _ YES 2 _ NO			
AN	DID TOBACCO USE CONTR	IBUTE TO CAUSE				UNCERTAIN	111					
PHYSICIAN:	EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:	ly one)							
₹ I	1 YES 2 NO	f hpatient 2 ER/O		4 - Nursin			6 Other (Specify)					
	27. MANNER OF DEATN  1 Netural 5 Pending	28a. DATE OF INJUR (Month, Day, Year		E OF 2	Bc. INJURY WORK?		28d. DESCRIBE NOW IN	JURY OCCURED				
BY	2 Accident Investigation					2 NO						
	3 Suicide 6 Could not be	28a. PLACE OF INJU building, etc. (S	RY — Al home, ferm, pecify)	street, lactor	y, offica		28f. LOCATION (Street at City or Town, State)	ld Number or Rural F	Route Number,			
E	4 Homicide detarmined											
2	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my kn	owledge, death occurr	ed at the time	e, data and	place, and due	to the cause(s) and mann	ver as stated.				
COMPLETED	one) 2 MEDICAL EXAMINER								) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER	01 0										
BE	The second secon	51	- 1/am	100	294	c. LICENSE NUM	464	29d. DATE SIGNED	(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLEE OF	DEATH (ITEM OT C	( ( ( )		- 14	1	JUNE (	0, 1775			
	SI C-IAO 1	10 Tana	Tion I I o	rnini)		m	12.500					
, l	31. DATE FILED (Month, Day, Year)	S PARN	ICK. OR	05/180	186	1111	21532					
<b>⋨</b> ▮	JUN 9 199	32. REGISTRAR'SISH	SHATURE RONDO	el.								
	2014 2 122	9 ()										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Debt of Heath and Mental Hydiene point to burial cremation or named.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ours after death. Page 6	d in by the funeral direct or removal	medical examiner m
ite be executed within 24 i	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fill be filled within 72 hours after death with the State Dent, of Health and Mental Hydlene entor to burdal cremation or removal	traumatic event, the
s that the death certifical	ned by the attending physical and Mental Hydiene	any injury, or other
SICIAN: The law require	certificate has been significate beore, of He.	d, or item 23 shows
AL OR ATTENDING PHY	AL DIRECTOR: After this 72 hours after death with	if item 28 is marke
THE HOSPIT	TO THE FUNER.	IMPORTANT:

	FOR STATE REGISTRAR	STATE OF I					HEALTH AND	MENT	AL HYGIEN		1	0 7 3 0
	1. DECEDENT'S NAME (First, Middle, Lest) ALICE	J.			BR	ow	N	2. DAT	E OF DEATH	AY	VEAD -	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213-74-9980	5. SEX	6. AGE (In yrs. Ia 9 4	st birthday) YRS.	MONTHS	DAYS	IF UNDER 24 HAS. HOURS MIN.	10	E OF BIRTH (1th, Day, Year) / 18/0(		Country)	ACE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give s Prince George' RESIDENCE OF DECEDENT		Cente	r			or Location of t	DEATH		PRINC		ORGES
DIRECTOR	Md . 10b. COUNT	P.G.		16c. CIT		est	ville				1.75	Dd. INSIDE CITY LIMITS?  YES 2 NO
FUNERAL	9306 Westp	halia R	d.			10	1. ZIP CODE 207	47		10g. CITIZE	N OF WHA	S.A.
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X	RMED NO	13.	If yes, sp	CENDENT OF HISPA recity Cuban, Maxic 2 2 NO Spec	en, Puerto		s or No — 1	4. RACE — Black, V Specify:	American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5	+)	). Do NOT u	work done se retired.)	during mo	ON ost of working	36	b. KIND OF BU		STRY	
	12th  17. FATHER'S NAME (First, Middle, Last)  Beaman Joh	nnson		Home	mak	er	18. MOTHER'S N		Own Middle, Maiden	Surname)		
TO BE	19a, INFORMANT'S NAME (Type/Print)	_	19	b. MAILING	ADDRES	S (Street a	and Number or Rural				ode)	
٦	Walter L. Brow	n		5100	Le	e S	t.,N.E,	, Wa	sh.,D	.С.	2001	19
	20e, METHOD OF DISPOSITION  1X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE cempetery, cm Har	and date	or dispo ther place MC	m.	Park 6/	1/9	те 20c. Lo	ndove	r, Mc	State
	21. SIGNATURE OF FUNERAL SERVICE LIC		eatt			H.S	Washin Burrou	ato	n & So Ave.	ons,i	nc.	
	23. PART i. Enter the diseases, or a shock, or heart failure.	complications the	t coused the de	ath. Do i	not ente	r the mo	de of dying, su	ch aa ce	rdlac or reap	iratory arres	it,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	SEPTI	CEMIC (OR AS A CONSE	SI	100	K						Onset and Death
TION	Sequentially list conditions, if any, leeding to immediate	SEPTI DUE TO	C GAN	G-REI	UE	, BC	TH FEL	FT				1 months
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ARIER DUE TO	(OR AS A CONSE	CULET OUENCE O	DRY	obs	Truction	k, b	oth los	ven le	gs_	5 moulhs
CC	PART II. Other aignificant condition	a contributing to	death but not	reaulting	in the u	nderivin	a cause alven in	Part i	240 WAS AM	AUTOREY	T 245 MM	THE AUTOROV CINDINGS
PHYSICIAN: MEDICA						_			PERFOR	MED?	AM CO OF	AILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?  YES 2 NO
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	s 🗆	NO D	UNCERTAI	N 🗆				
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO	HOSPITAL:		E OF DEA	OTHE	R:						
ву РНУ	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, D	INJURY	26b. TIM		28c. INJ WO	URY AT PRK?	-	er (Specify) SCRIBE HOW I	NJURY OCCU	RED	FL I
	3 Suicide 6 Could not be detarmined	28s. PLACE O building,	F INJURY — At he atc. (Specify)	me, term, s	street, tec	tory, offic	0	28t, LO City	CATION (Street a or Town, State)	and Number or	Rural Route	» Number,
COMPLETED		CIAN: To the best of										nd menner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NU D 2597					onth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO	O COMBI ETED CALIF	SE OF BEATH ATE		D 1 11						-	

BeThesda Md

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

J. BERGER #205, 7720 WISCONSIN AVE,

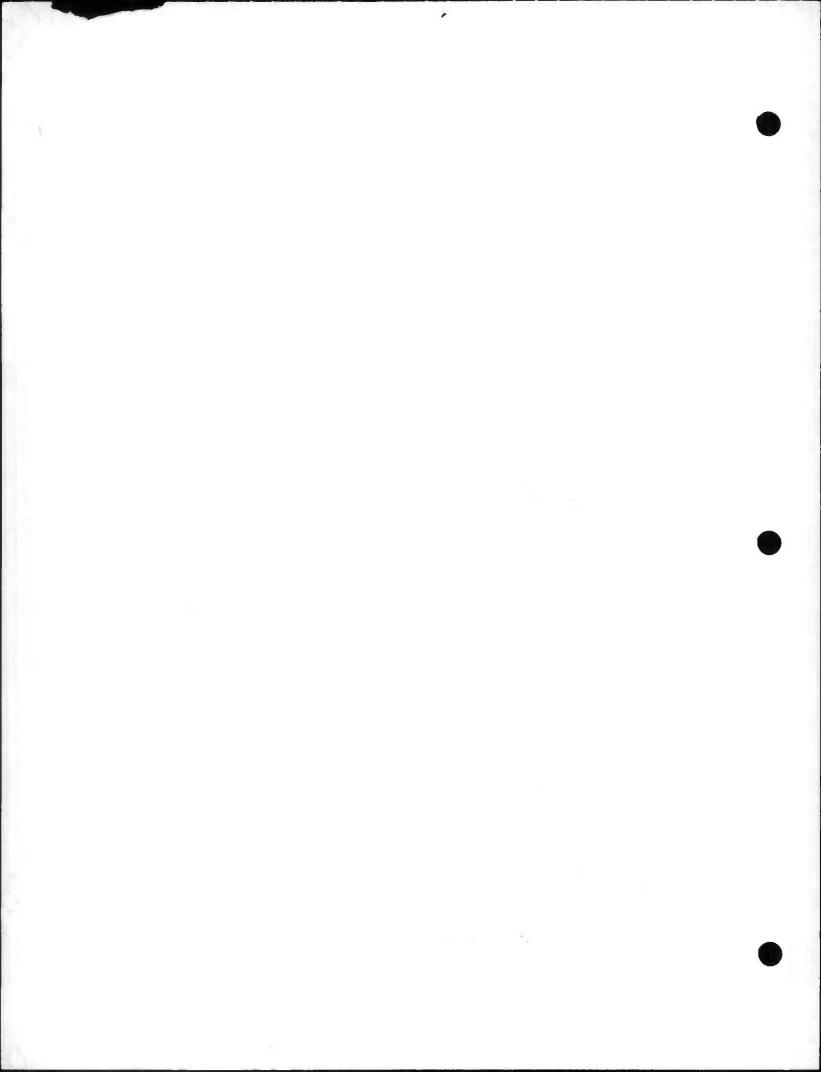
32. REGISTRAR'S SIGNATURE

J. BERGEZ

31. DATE FILED (Month, Day, Year)

JUN 06 1995

20814



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P.O. BOX	
CORDS,	
F VITAL RE	
DIVISION OF	
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TENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria-transit nermit Panes 1.2	if death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	to marked as them 22 shows before as alkas businessed and a second and a second as a second as
IYSICIAN: The	is certificate h	ith the State [	ad or Ham
TENDING PH	DR: After th	ter death w	a is mark
AL OR ATT	AL DIRECT	2 hours af	H Ham 20
THE MOSPIT	THE FUNER.	iled within i	POPTAMT.
2	[ OT ]	20	18.40

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

Jenjen MD

J. BERGER MD

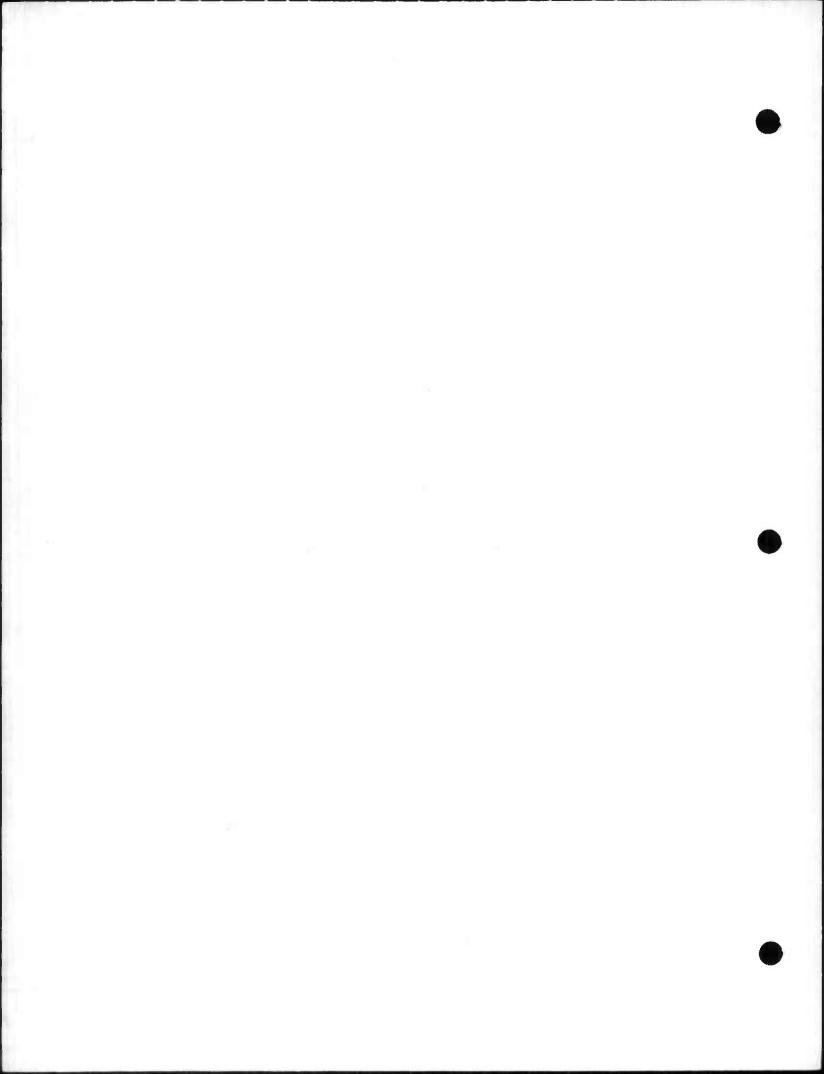
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 WILLIAM BRAXTON, JR JUNE EDWARD 9:50 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 06/04/67 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 577-06-5392 1 💢 M 2 🗌 F 27 YRS. Washington, DC 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's Hospital DIRECTOR PRINCE GEORGE'S Center RESIDENCE OF DECEDENT 10a. STATE 10d. INSIDE CITY D.C. Washington XX YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5409 Nannie Helen Burroughs Ave. 20019 NE United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 TES 2 XNO BY Specify: 3 Widowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION

If a district of work rione during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12th grade Police Officer D.C. Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surni William Edward Braxton, Sr. Lorraine E. Ward 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip ches Shington, D 2 Lorraine E. Braxton 5409 Nannie Helen Burroughs Ave. NE 20e. METHOD OF DISPOSITION
X X Burlel 2 Cremetion 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Harmony Memorial Park6/6/95 4 Donation 6 Other (Specify) Landover, Md. 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY
Capitol Mortuary 1425 Maryland Avenue, N.E. Wash.DC 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Fine) Onset and Death** disease or condition\_ VENTRICULAR FIBRILLATION resulting in death) minutes DUE TO (OR AS A CONSEQUENCE OF) CAPDIOMY OPATHY
DUE TO (OR AS A GONSEQUENCE OF): Years Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 ☐ Inpetient 2 € ER/Outpetient 3 ☐ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29e. CERTIFIER 1 \_\_\_, CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dev. Year)

> #205 7720 WISCONSIN AVE, BeThesda Md 20814 32. REGISTRAR'S SIGNATURE

D25925

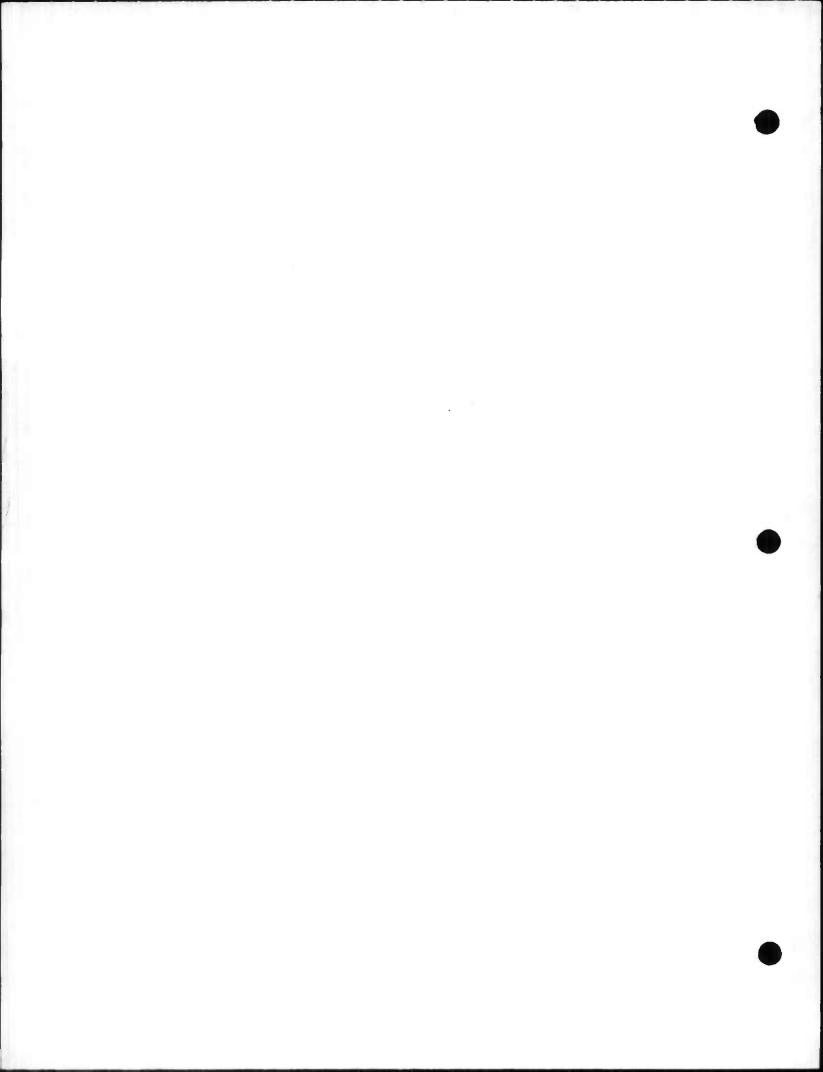
NESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



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THE HIGH MAY BATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer narmit Pages	filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	APORTANT if item 28 is marked or item 23 shows any injury or other traumatic event the medical examinar must be notified at annot
推用	THE FU	filed with	PORTA
len.	0	-	=

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND N	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA	AY YEAR	3. TIME OF DEATH	
	ROBERT		ROWN , JF	₹.			14 1995	8PM M	
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Mgnth, Day, Year)	Cou	THPLACE (State or Foreign ntry)	
			YRS.		3	2/15/32	Wa	sh.,D.C.	
r	9a. FACILITY NAME (If not institution, give stree Prince George's				OR LOCATION OF DE	ATH	9c. COUNTY OF		
DIHECTOR	RESIDENCE OF DECEDENT	, nosp. ce	nter	Chet	verly		Prince	George's	
표	10a. STATE 10b. COUNTY	D. C.		OWN OR LOCAT				10d. INSIDE CITY LIMITS?	
5	Md.	P.G.	Seat	Plea	sant			1 XYES 2 NO	
PUNEHAL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN OI	WHAT COUNTRY?	
	518 Birchl				20743		U.S.	Α.	
2	11. MARITAL STATUS  1 Never Married 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO			IC ORIGIN? (Specify Yes	or No — 14. RA	CE — American Indian, ick, White, atc.	
a a	3 Widowed 4 Divorced	Korea	res	1 🗆 YES	2 NO Specify		Sp	Black	
3	15. DECEDENT'S EDUCAT (Specify only highest grade con	TION	16a. DECEDENT'S USI	JAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUSTRY		
		College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during mo tired.)	st of working				
1	4	yrs.	Machini	.st		Plant	Operat	ions	
3	17. FATHER'S NAME (First, Middle, Last)					AE (First, Middle, Maiden			
	Robert L. B	rown, Sr.				ia Steve			
2	190. INFORMANT'S NAME (Type/Print) Audrey C. Brown					oute Number, City or Town	n, State, Zip Code)		
	20a. METHOD OF DISPOSITION		Same		10 abov				
	1 🔀 Buriel 2 🗆 Cremation 3 🗆 Remova 4 🗆 Donation 5 🗀 Other (Specify)	I from State cerue	tery, cremetory or other a LMONY M.	place)	9/95 Landover, Md.				
	21. SIGNATURE OF FUNERAL SERVICE LICENS		armony F.	22. NAME AN	D ADDRESS OF FAC	Nan Trail	dover,	Mu.	
	· Xany	1. Prate	-	H. 492	S.Washi 5 Burro	ngton & ughs Ave	Sons, I	nc.	
CONTENT OF THIS COM. MEDICAL CENTIFICATION	27. MANNER OF PEATH  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be datarmined  29a. CERTIFIER (Check only)	DUE TO (OR AS A OF STREET	CONSEQUENCE OF:  CONSEQ	NO Date of the time, data	UNCERTAIN  5   Residence of the AT    and place, and due to	Other (Specify)  28d. DESCRIBE HOW IN  281. LOCATION (Street as City or Town, State)  to the cause(a) and men	NURY OCCURED  Ind Number or Rura  Ther as stated,  If due to the cause		
	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEAT	H (ITEM) 27) (Type, Prin	0 11	D-34.	525	<u>▶ 06</u> -	2-9-20	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNAT		rill-	PWOO;	#220; I	BAMG-	My-20716	
	JUN 08 1995 Jahr	daveles had	Щ						



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

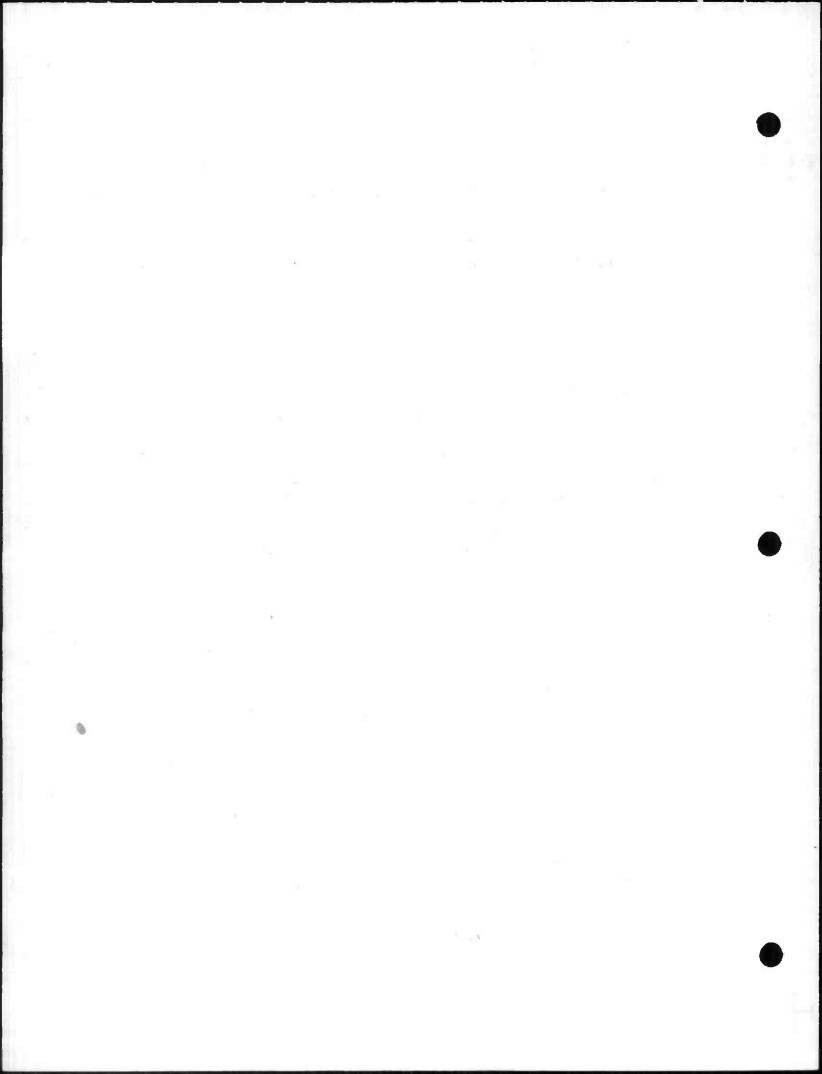
TO HE FINETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be a written 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

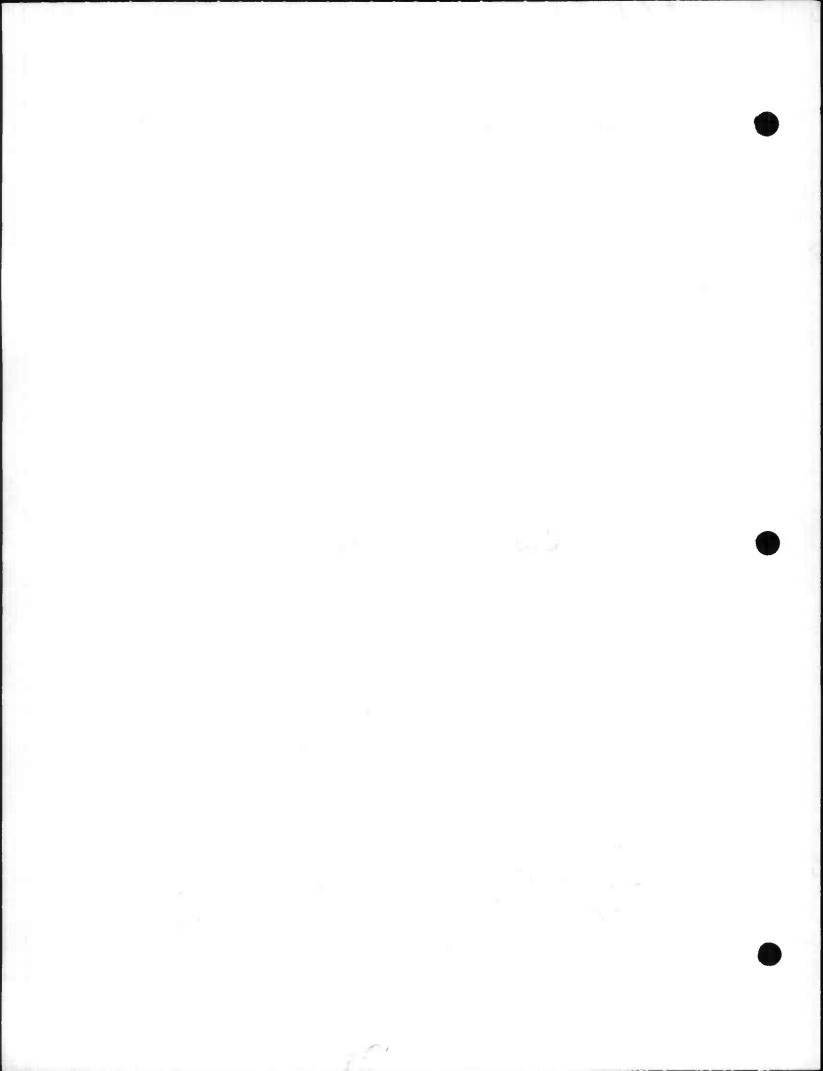
1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

	HEGISTHAN				-NIII	ICALE	UF	DEAL	I II		REG. NO.				
- 8	1. DECEDENT'S NAME (First) RICHARD		n	ATTED						2. DATE O	D/		YEAR	3. TIME OF DEATH	
1	4. SOCIAL SECURITY NUMBER	DEMME	5. SEX	AUER  6. AGE (In yrs. les	A Stable of mile					Jun		, 1	995	4:50 A M	
	169-16-616		1 ☑ M 2 ☐ F	7.4	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE O (Month,	Day, Year)	1000	Countr	PLACE (State or Foreign y)	
	9a. FACILITY NAME (If not in			74	THO.	Oh CITY	Dec. 25, 1920 Pen								
Œ	6100 Westch	_	,	ad #1003								9c. COUNTY OF DEATH			
DIRECTOR	RESIDENCE OF DEC		Talk No	1003	College Park							Prince George's			
R	10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS?	
	Maryland	Prince	e George	t s	College Park						1			1 YES 2 NO	
FUNERAL	10e. STREET AND NUMBER							ZIP CODE			10g. CITIZEN OF WHA			HAT COUNTRY?	
ÿ	6100 Westch	nester						20740	0			.A.			
F	11, MARITAL STATUS  1 Never Merried 2 X	Merried	FORCES? 1	T EVER IN U.S. AR		13.	WAS DEC	ENCENT O	F HISPAN	IIC ORIGIN?	(Specify Yes	or No-	14. RACE Black	- American Indian, White, etc.	
ВУ	3 Widowed 4 Divo		IF YES, OIVE V	WAR OR DATES		1	YES	5 X NO	Specify	r.			Specifi	ochy: White	
		EDENT'S EDUC		18e. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16b I	(IND OF BUS	INESC/IN			
COMPLETED	(Specify only Elementary/Secondary (0	y highest grade (	College (1-4 or 5	(G	Do NOT us	work done (	during mo	st of workin	ng	133.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5001111		
릴		-	5+		ctor					M	edica:	1			
S I	17. FATHER'S NAME (First, M					·		16. MOTH	HER'S NA	ME (First, Mi	ddle, Malden	Sumame)			
BE (	Edward Loui	is Baue	er					C1a	ara 1	Eisen	hardt	Ban	er		
5	19a, INFORMANT'S NAME (7										r, City or Town				
- 1	bodiainia v. badei   0100 westchester Park Drive #1003, College Park														
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	val from State	cometent cre	metany or a	ther place)				OATE					
	4 Donatton 8 Other (Specify) Metropolitan Crematory 6/2/95 Alexandria, Vir												Virginia		
	21. SIONATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Francis Gasch's Sons Funeral Home, P.A.														
	I ALT	5. 6	. orde											MD 20781	
	23. PART I. Enter the di	seasea, or c	omplications the	t caused the de	eth. Do r	ot enter	the mo	de of dyi	ng, aucl	n aa cardi	oc or reapl	ratory ar	reat,	Approximate	
	ahock, or heart fallure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition )  Onset and Death														
	disease or condition														
			OUE TO	(OR AS A CONSEC	UENCE O	F):	7		1,100					1	
NO	Sequentially list conditi	ions.					V								
Ā	if any, leading to immed cause. Enter UNDERLYI	diete	DUE 10	(OR AS A CONSEC	DUENCE OF	F):									
임	CAUSE (Disease or inju- that initiated events		OUE TO	(OR AS A CONSEC	UENCE OF	F);								-	
CERTIFICATION	resulting in death) LAS	, I													
8			•												
EDICAL	PART II. Other aignifice	nt conditions	contributing to	death but not r	eaulting i	in the un	derlying	cause g	given in	Part I.	PERFOR		246.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
ă										_	YES 2	NO		COMPLETION OF CAUSE OF DEATH?	
M								-		_				1 - YES 2 - KNO	
Ž	DID TOBACCO U		IBUTE TO CA			- 17		UNC	ERTAIN	1 🗆			19		
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		E OF DEAT	OTHER	1								
IYS	1 TYES 2 NO		1   Inpetient 2						aldenca	8 Other (					
		Pwnding	28a. DATE OF (Month, D		28b. TIM	URY M	26c. INJU	RK?		28d. DESC	RIBE HOW IN	JURY OC	CURED		
B⊀		Investigation	28e PLACE O	F INJURY At ho	no form o	Total fact	1  Y	-	NO						
9	the second secon	Could not be determined	building,	atc. (Specify)	170, 101111, 0	ereer, recr	ory, orne			City or	ION (Street a Town, State)	nd Number	or Hural H	oute Number,	
9	284. СЕЯЗИЧЕЯ	EVINO TOTAL	4				_								
CERTIFYINO PHYSICIAN/To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated.  Significant Control of the cause (a) and manner as stated.  The control of the cause (b) and manner as stated.  The control of the cause (c) and due to the cause (c) and manner as stated.															
	296 STORMTUNE MONTHE	-4-1	To the best of 81	and/of t	···vestigatio	···, iii my o	pirmon, de	-	_		nd place, and		-/		
BE	NA IN	N/M	maker	h 1				500 LICE	NSE NUM	BER		29d. DAT	E SIGNED	Month Day Wall	
O	30. NAME AND AODRESS OF	PERSON WHO	COMPLETED CAME	////	1 22 77	Defeat.		10	01	)4		- 6	2/2	195-	
1	Thomas Bens						Cont	or D	mi	#205	C	0=1	1.	WD 20770	
/	31. DATE FILED (Month, Day,			PO SIGNATURE	reell	way	cent	er D	TIVE	# 203	, Gre	епре	III,	MD 20770	
	111N 06 1995	July	82. REGISTRA	Sadal .											
السيا	THE OF MAN	0		-				-						DHMH-18 Rev 1/89	
1															



		FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR RTIF	ITMENT OF I	IEALTH AND	MENTAL HYG	IENE	18962	
		1. DECEDENTIS NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER	S Ralph &	Starks E		IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEAT PHONTH  C/Ne  7. DATE OF BIRTH	3. TIME OF DEATH  /2 // /// M  BIRTHPLACE (State or Foreign		
3 should	J. B.	160-42-4036  90. FACILITY NAME (If not institution, give s		46	YRS.		HOURS MIN. OR LOCATION OF E	May 16,	949 P	Pittsburgh, Pa. COUNTY OF DEATH Cince Georges	
rmit. Pages 1, 2,	L DIRECTOR	904 Congress Place RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Prince 10c. STREET AND NUMBER				y, town on Loca idover, Ma	rion aryland	iiu		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
215-0020 attending physician. se as the burlatransit permit. Pages	Y FUNERAL	904 Congress Place 11. MARITAL STATUS 1X Never Married 2  Married	12. WAS DECEDEN	IT EVER IN U.S. ARI	MED O	13. WAS DEC		NIC ORIGIN? (Specifian, Puerto Rican, etc	U.S y Yes or No.— 14	I. RACE — American Indian, Black, White, etc.	
- 8 J	PLETED BY	3 Wildowed 4 Divorced  15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5	18a. DE( (Gir life.	CEDENT'S re kind of v Do NOT us	USUAL OCCUPATION Work done during more retired.)	ON	16b. KIND OF	BUSINESS/INOUS	Black Bray	
MARYLAND 2 retained by the hospital 5 should be detached to	i iii	17. FATHER'S NAME (First, Middle, Lest) Aaron Starks St  19a. INFORMANT'S NAME (Type/Print)	ne Year			cian		AME (First, Middle, Ma Blye		118	
BALTIMORE, MAR ir death. Page 6 may be retained the funeral director, page 5 should val.		Per Homer S. Starks Brother    19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   2412 Franklin Street N.E. Apt. 114   2412 Franklin Street N.E. Apt. 114   2412 Franklin Street N.E. Apt. 114   261. NE. Apt. 114   262. LOCATION - City of Street N.E. Apt. 114   263. METHOD OF DISPOSITION   DATE   264. LOCATION - City of Street N.E. Apt. 114   264. LOCATION - City of Street N.E. Apt. 114   265. LOCATION - City of Street N.E. Apt. 114   266. LOCATION									
By the redical of the medical of the the medical of the the medical of the the medical of the the the the the the the the the the		23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one ceu	ise on each line.	ukin	3447-1	4th Stre	et, N.W.W	ashingto	t, Approximata interval Between Onset and Death	
P.O. BOX 68:  The certificate be execute anding physician and co Hygiene prior to buria or other traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	С.	(OR AS A CONSEQ							
RECORDS, Proceedings of the death peer signed by the attern of Health and Mental shows any inlury, or shows any inlury, or the state of	ME	PART II. Other significant condition	splant	1994			g ceuse given in	PEF	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?  1 YES 2 NO	
CIAN: The law certificate has but the State Dept.	HYSICIAN	DID TOBACCO USE CONTI 25. WAS CASE BEFERRED TO MEDICAL EXAMPLE 7: 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	26. PLACE ER/Outpetient 3 INJURY	DOA 28b. TIM	E OF 28c, INJ		8 Other (Specify)	DW INJURY OCCUP	NED	
DIVISION OI  OR ATTENDING PHYS DIRECTOR: After this of hours after death with	ETED	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At hon atc. (Specify)		kreet, factory, offic		City or Town, S	itate)	Rural Route Number,	
THE HOSPITAL OF THE FUNERAL DIFFER WITHIN 72 ho	3	(Check only							a, and due to the c	igned (Month, Day, Year)	
PP3	2	50. NAME AND ADDRESS OF PERSON WAS	COMPLETED CANS	SEOF DEATH (ITEM	27) (Type,	Print) Part I	H712	Ca. Sa	· Mis-	5,1995	
	1	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	,	1-11		1		171	



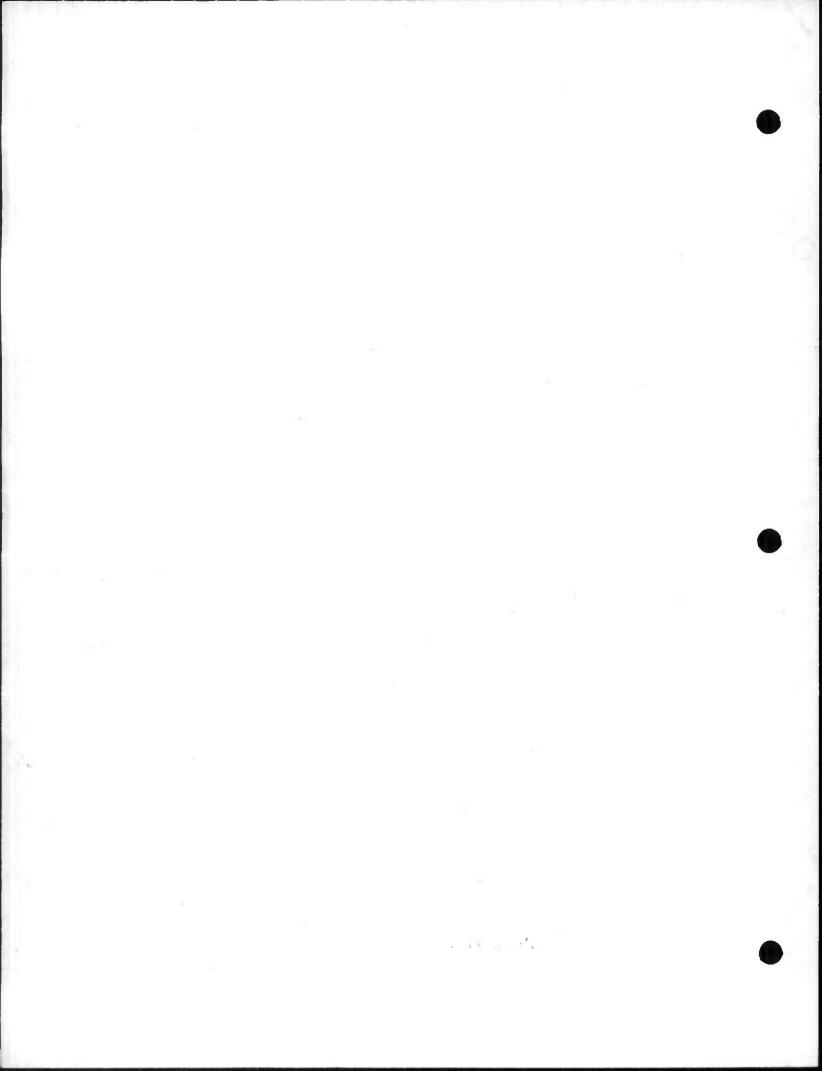
BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours into each Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the turner of page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART	MENT OF I	IEALTH AND I	MENTAL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) Robert		Blackwell Blackwell					3. TIME OF DEATH 10:05A M		
	4. SOCIAL SECURITY NUMBER 578-54-2788	1 X M 2 🗆 F	E (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cor	THPLACE (State or Foreign intry) Shington, DC		
TOR	DOCTOR'S HOSPI  RESIDENCE OF DECEDENT				am, MD.	ATH	P.G	DEATH		
DIRECTOR	10e. STATE 10b. COUNTY	P.G.		TOWN OR LOCA	ille, M	d.		10d. INSIDE CITY LIMITS? 1X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 11108 Lake Arbo	or Way	,	10	20721		10g. CITIZEN O	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2X NO	If yes, sp	ENCENT OF HISPAN ecity Cuben, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	81	CE — American Indian, ack, White, etc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) College (1-4 or 5+)	life. Do NOT use	ork done during mo		16b. KINO OF BUS	Offic			
BE CON	17. FATHER'S NAME (First, Middle, Leat) Henry Blackwel	11		02027	the state of the s	ME (First, Middle, Meiden S te Shedr:	Surname)			
10 8	190. INFORMANT'S NAME (Type/Print)  Larry Blackwe					ay, Mitcl		20721 lle,MD.		
4	20a_METHOD OF DISPOSITION 1		Ob. PLACE AND DATE Of emetery, crematory or oth Harmony	er place) Cemet	erv May	30,1995	Landov			
	21. SIGNATURE OF FUNERAL SERVICE LIC	Millien	750	Ra1p		ams Funer				
	25. PART I. Entar the diseases, or o shock, or heart feilure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Metas	tatic	Head	de of dying, auch	n as cardiac or respir	cance	Approximata interval Between		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
A	PART ii. Other significent condition	d. a contributing to death	but not resulting in	the underlyin	g ceuse given in i	Part i. 24s. WAS AN A PERFORI	MED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
YSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	tpetlent 3 DOA	OTHER:	e 5 🗆 Realdence	6 Other (Specify)				
à	27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 8 Could not be detarmined	28e, DATE OF INJURY (Month, Day, Year) 28e, PLACE OF INJUR building, atc. (Sp	INJU	M 1 .	RK? 'ES 2 NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	290. CERTIFIER (Check only	CIAN: To the bast of my kno						e(a) and manner as stated.		
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER		)		29c. LICENSE NUM D-33			ED (Month, Day, Year) 126, 1995		
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE OF O	1227-B	Hanu	ver pa	nkway G	reenbe	1 mp 20770		
	UN 66 1995 AL	Buderhan	4		,			DHMH-16 Rev 1/89		
								Primit-10 Les 1/9		



BALTIMORE, MARYLAND 21215-0020	hours after death, Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	madical avaminar must be notified at each
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the full be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT II them 28 is marked on them 23 shows any injury or other traumatic events as available must be nestigated as exact.

			-	+-				95	18964	
	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGI REG.				
	1. DECEDENT'S NAME (First, Middle, Lest) PHILIP	THA	YER	BRO	WN	2. DATE OF DEATH	DAY 26	1995	3. TIME OF DEATH	
	122-26-8078	1 🗓 M 2 🗆 F 6	(În yrs. lest birthdey) 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	27	New t	Jersey	
TOR	96. FACILITY NAME (If not institution, give stre 2602 Brinkley Roa RESIDENCE OF DECEDENT				Hills	ATH		NCE	GEORGE'S	
DIRECTOR	10a. STATE 10b. COUNTY	ce George's	t0e. CIT	Y, TOWN OR LOCAT	Temple H	ills		- 1	10d. INSIDE CITY LIMITS? 1 YES 2 (X) NO	
FUNERAL	100. STREET AND NUMBER 2602 Brinkley Roa	ıd		101	ZIP CODE 207		10g. CI		HAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2X NO	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexical 2 X NO Specify	n, Puerto Rican, etc.)	Yes or No-	14. RACE Black, Specify		
LETED	15. OECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)		(Give kind of life. Do NOT u		st of working	16b. KIND OF			White	
COMPLET	17. FATHER'S NAME (First, Middle, Last)	4	weatne	r Bureau		ME (First, Middle, Mai	Gover			
BE C	Walter B. Brown				11.	. Vogeli	-			
TO E	19a. INFORMANT'S NAME (Type/Print) Audrey Brown		19b. MAILING 116 W	. Univer	nd Number or Rural F Sity Par	loute Number, City or	Town, State, 2	e, MD	21210	
	20s. METHOD OF DISPOSITION  1	ral from State 09	PLACE AND DATE	of olsposition (Ne tan Crem	natory 6-			- City or Tow		
	21. SIGNATURE OF FUNEFAL SERVICE LICE	HSEE,	M00173	J.H.	Eberwein	Mortuar	y			
	shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final								Approximate interval Batwean Onset and Death	
	resulting in death)  s. CEREBROVASCULAR ACCIDENT  DUE TO (OR AS A CONSEQUENCE OF):									
RTIFICATION	Sequentisity list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury  c.									
CERTIFI	that initiated events  resulting in death) LAST  d.									
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.  Chrous part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.  PERFORMED?  AMAIL  COM									
PHYSICIAN: MEDICAL	OF 6								OF DEATH?	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA		OTTOERIAII	1 121				
HYSI		1 ☐ Inpetient 2 ☐ ER/Outs 28s. DATE OF INJURY	petient 3 DOA	4 - Nursing Hom		6 Other (Specify) 28d. DESCRIBE HO	W IN HIEV O	CHIPED		
ВУ РІ	1 Natural 5 Pending	(Month, Day, Year)		URY WO	PK7	Zeu. DESCHIBE NO	w industrion	CONED		
	3 Suicide 8 Could not be 4 Homicide detarmined	26s. PLACE OF INJURY building, atc. (Spec	' — At home, farm, i	street, factory, offic		281. LOCATION (Stra City or Town, Str	el and Numbe	er or Rural Ro	ute Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER:	AN: To the bast of my know On the basis of sxamination	ledge, death occum n snd/or investigatio	ed at the time, data on, in my opinion, d	and place, and dus	to the cause(s) and i	nanner as at	nted. Ihs csuse(s)	and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER			Month, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	e Bet	hacke		708	, 1995	
	31. DATE FILED (Morith, Day, Year) JUN 1 3 1995		ATURE Rawfall	-110 110				200	.7.	

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BALTIMORE, MARYLAND 21215-002	AM: The law requires that the death certificate be executed writing hours after death. Page 6 may be regained by the ho
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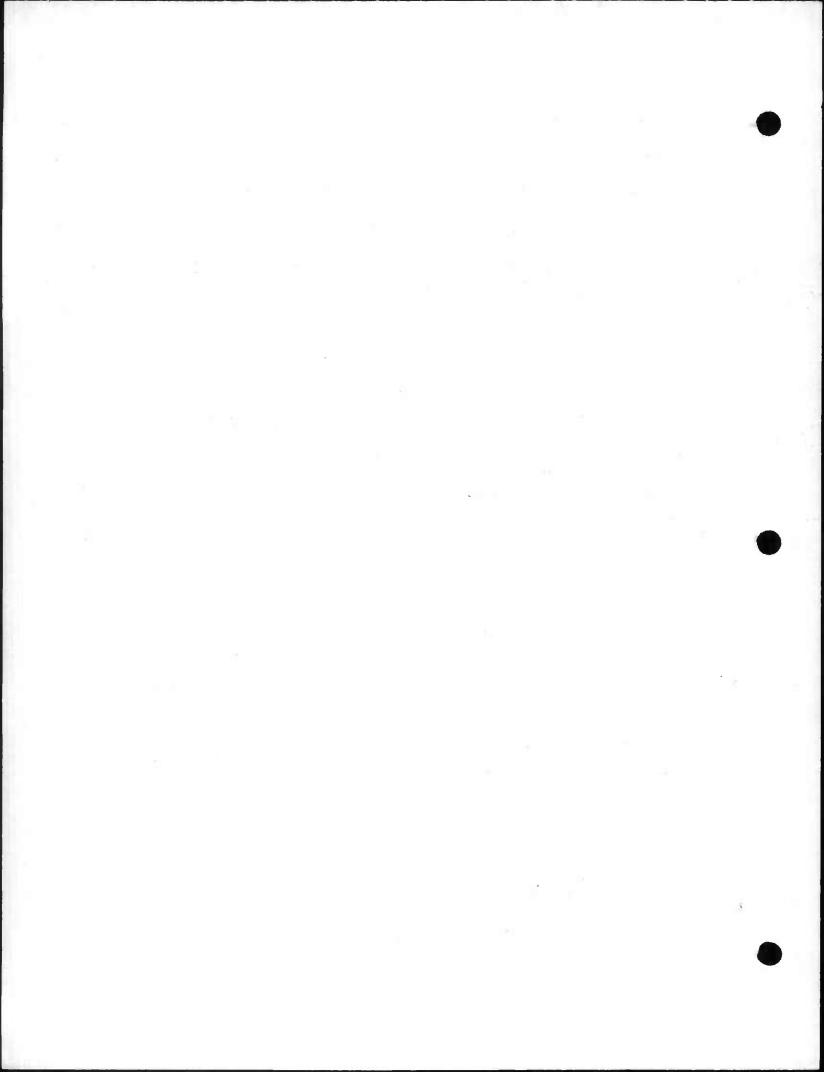
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MENDETIANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALT	
CERTIFICATE OF DE	ATH REG. NO.

	1 - FOR STATE REGISTRAR	E OF MARYLAN	D / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH	3. TIME OF OEATH									
	Betty Norene Bachma		June 9,		2245 M							
	4. SOCIAL SECURITY NUMBER 5. SEX			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign				
	578-36-2894 1 🗆 M	11	4 YAS,	ONTHS DAYS	HOURS MIN.	Dec 17, 1	930 County of I	Wash DC				
DIRECTOR	Calvert Memorial Ho				Frederi		Calve					
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY				
	MD Calve	ert		Hunting	town			LIMITS?  1 YES 2X NO				
FUNERAL	104. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
N	1845 Cliff Drive				20639			S.A.				
BY FU	1 Never Married 2 1 Married FORG	DECEDENT EVER IN U.S XES? 1 YES 2 S, GIVE WAR OR DATES	<b>⊠</b> NO	If yes, sp		NIC ORIGIN? (Specify Yes an, Puerlo Rican, etc.) fy:	or No — 14. RAC Blec Spec	E — American Indian, ik, White, etc.				
	15. OECEDENT'S EDUCATION	164	. DECEDENT'S U	BUAL OCCUPATION	N	16b. KIND OF BUS	INESS/INDUSTRY	WILLE				
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College	(1-4 or 8+)	(Give kind of worlde, Do NOT use	rk done during mo retired.)	st of working							
MPI	12		Christia	an Scie	nce Nurs	e Health	h Care					
00	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Malden						
B	Issac		Sayre		Bessi			Swan				
2	190. INFORMANT'S NAME (Type/Print)  Jerry W. Bachman					Route Number, City or Town						
		20h 81 4	CEANDDATE OF			ntingtown,	MD 2063 CATION — City or To					
	20a. METHOD OF DISPOSITION  1	State cemetery	crematory or othe	place Crema	atory 6-	11-95 Alex	xandria,					
	21. SIGNATURE OF SUIVERAL SERVICE LICENSEE	11	L		D ADDRESS OF FA		and la,	VA				
	Age To	O CH	rh- o	Rausc	Funera	1 Home, PA	Owings	MD				
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  OUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):											
AL	PART II. Other significant conditions contrib	uting to death but n	ot resulting in	the underlying	ceuse given in	Dennan		. WERE AUTOPSY FINDINGS				
MEDIC						1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
뿔					1			1 - YES 2 - NO				
Ž		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 1 June	TAL:		THER:								
₹		DATE OF INJURY	28b. TIME (	-		8 Other (Specify)	HIEW COOLINGS					
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	M 1 WO	RK?	26d. DESCRIBE HOW IN						
	3 Suicide a Could not be 4 Homicide detarmined	PLACE OF INJURY — A building, atc. (Specify)	it home, farm, stre	et, factory, office		281. LOCATION (Street as City or Yown, State)	nd Number or Flural i	Route Number,				
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the management of the second of the secon							i) and manner as stated.				
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	^			29c. LICENSE NUI	MBER /	29d. DATE SIGNED	(Month, Day, Year)				
	/W./v				1)463	314	D (5)	0/15				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLE				7 00-	70	<u> </u>					
	Dr. Paul Pomilla M.D.		Freder	ick, M.	d. 2067	/8						
	31. DATE FILED (MORRI), Day, Year)  32. F  JUN 1 3 1995	Lin Davidson	Parti									
	OON T 9 1992 3	in arminent	vandally									



**BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	ATE OF MARYLAN		TMENT OF		MENT	AL HYGIEN			
	DECEDENT'S NAME (First, Middle, Last)  Ch						TE OF DEATH		EAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER 5. SE		rs. lest birthday)				ne 8.	1995	BIRTHP	2020 M
	383-34-3684	M 2 💢 F	8 YRS.	MONTHS DAYS	HOURS MIN.		onth, Day, Year) 7. 25, ]	-	Country)	
	9a. FACILITY NAME (If not institution, give street and	d number)		96. CITY, TOWN	OR LOCATION OF D		• 20, 1	9c. COUNTY		
OR	134 Friendship Road	1		Elkto	n			Ceci	1	
ן ק	RESIDENCE OF DECEDENT		I							
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION  Maryland Cecil Elkton							- 1	IOd. INSIDE CITY LIMITS?	
	100. STREET AND NUMBER		El		of, ZIP CODE					YES 2 NO
RA	134 Friendship Road	1		1	21921			U.S		IAT COUNTRY?
FUNERAL		AS DECEDENT EVER IN U.	S. ARMED	13. WAS DE	CENDENT OF NISPA	NIC OBIC	SIN7 (Specify Vac			- American Indian.
	1 Never Married 2 Married	ORCES? 1 YES	2 NO	If yes, a	pecify Cuben, Mexico S 2 X NO Specif	an, Puert		G 100	Black,	White, etc.
BY	3 Widowed 4 Divorced			1 .0.15	A NO Specia	чу.			Specify:	White
	15. DECEDENT'S EDUCATION (Specify only highest grade comple	ted) 18	e. DECEDENT'S	USUAL OCCUPAT work done during in se retired.)	ION ost of working		66. KIND OF BUS	SINESS/INDUS	TRY	
	Company of the Compan	ege (1-4 or 5+)								
COMPLETED	1.1 17. FATHER'S NAME (First, Middle, Last)		Nurses	Aid			Nursing			
	Charles E. H	Herd			18. MOTHER'S NA					
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural		atrice			10
임	John W. Brown, Sr.				ip Road				921	
	20e, METHOD OF DISPOSITION	20b. PL	ACE AND DATE	DE DISPOSITION /	leme of	1 04	TE 200 LO	CATION CH	y or Town	n, State
	1 N Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	om State comete Gil	ry, crematory or o pin Man	ther place) or Memo	rial Parl	k 110	05 E1k	cton.	Marv	land
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Λ .		22. NAME /	ND ADDRESS OF FA	CILITY FOT	Funeral	s. P.	Α.	
	Donald &	thecho		103	West Sto	ockt	on Stre	eet		
	23. PART i. Enter the diseases, or compile	cations that caused th	ne death. Do r	not enter the m	ton, MD ode of dying, suc	ch aa ce	rdiac or respi	retory arres	t,	Approximate
	shock, or heart failure. List or IMMEDIATE CAUSE (Final	nly one cause on each	ine.							Interval Between Onset and Death
	disease or condition								6 days	
8	Sequentially list conditions, b.	Diarrhea								3 months
TA.	if any, leading to immediate cause. Enter UNDERLYING	7.24	DASEOUENCE OF	-):						2
띮	CAUSE (Disease or injury that initiated events	AIDS DUE TO (OR AS A CO	ONSEQUENCE OF	F):						2 years
CERTIFICATION	reaulting in death) LAST									!
	PART II. Other algnificent conditions cont	ributing to death but	not requiting	n the underlyis	a sausa alum la	Boot I	24a, WAS AN			
SAL S		deling to deeth out	not resulting	ii the underlyn	ig cause given in	Part I.	PERFOR		A	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
							1 TYES 2	□ NO	0	F DEATH?
Σ	DID TOBACCO USE CONTRIBUT	TE TO CAUSE OF I	DEATH YE	S I NO I	TINICEPTAII	ΝП			1	YES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL			H (Check only one		МП				
Sic	EXAMINER?  1 YES 2 NO 1 I	SPITAL: npetlent 2 - ER/Outpetle	ent 3 🗆 DOA	OTHER:	ne 5X Residence	4   OH	her (Specify)			
PHYSICIAN: MEDIC	**	(Month, Day, Year)	28b. TIM	E OF 28c, IN	JURY AT		ESCRIBE HOW IN	NJURY OCCUP	RED	
ВУ	1 📉 Natural 5 🗌 Pending 2 🔲 Accident Investigation				YES 2 NO					
		te. PLACE OF INJURY — building, etc. (Specify)	At home, term, s	treet, factory, offi	ce	28f. LC	CATION (Street a	nd Number or	Rural Rou	ite Number,
	L CONTROL MARKET									
린	29a. CERTIFIER (Check only one)									
COMPLETED	2 MEDICAL EXAMINER: On the	he basis of examination ar	nd/or Investigatio	n, in my opinion,	death occured at the	time, da	ts and place, and	d due to the c	euse(s) s	and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			29d. DATE S	IGNED (A	fonth, Day, Year)
2	The fartes, My				1153			6/9	9/91	
	W. Farkas, M.D No				3		h Bridg	-	eet	
			_		E1kt	on,	MD 219	121		
	31. DATE FILED (MONTH, Day, 1997) 3 1995	Talia Daviden	Rodall							- 1
_										DHMH.18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	In the first with the state of	IMPORTANT Hism 28 is marked, or item 23 shows any injury, or other traumatic event. The medical examiner much he neating
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		FOR	CTATE OF MADVI AND	DEDAG	THENT OF	MEALTH AND		95	18961		
	_	1 - STATE REGISTRAR	STATE OF MARYLAND /	ERTIF	ICATE C	F DEATH	MENIAL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY YE	3. TIME OF DEATN		
			Joseph Howard				June 3	. 1995	1000 M		
			SEX 6. AGE (In yrs. les	YRS.	MONTHS DAY		7. DATE OF BIFTN (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
3 should		146-03-8445 1  9e. FACILITY NAME (If not institution, give street	7.0	tho.	9h CITY TOW	ON OR LOCATION OF D	March 18,				
	O.B.										
&S	ECT	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LO	CATION			Leading		
permit. Pages 1, 2,	DIRECTOR	Maryland Cecil		Ι.	kton.				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
. is	FUNERAL	314 Curtis Avenue				101. ZIP CODE 21921		U.S.	OF WHAT COUNTRY? A.		
fing physician. the burial-transit	8≺	11. MARITAL STATUS  1 Never Married 2 Nerried  3 Wildowed 4 Divorced	R. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 XI IF YES, GIVE WAR OR DATES	MED NO	It yes,	DECENDENT OF NISPAN , specify Cuben, Mexica YES 2 X NO Specify			RACE American Indian, Black, White, etc. Specify: White		
r attending use as the	ETED	15. DECEDENT'S EDUCAT (Specify only highest grade con		CEDENT'S	USUAL OCCUP	ATION most of working	16b. KIND OF BU	SINESS/INDUST	RY		
ا ۾ کو	IPLET		College (1-4 or 5+)	Sarge	se retired.)	most or working	Law E	nforcem	nent		
by the hospital be detached to at once.	BE COMPL	17. FATNER'S NAME (First, Middle, Last) William Ro	bert Black			16. MOTNER'S NA	ME (First, Middle, Melden Lillian I		lack		
5 should	TO B	19a. INFORMANT'S NAME (Type/Print) Grace G. Black					Route Number, City or Tow Clkton, MD	n, State, Zip Cod			
may be		20a. METNOD OF DISPOSITION	20h PLACE	NDDATE	DE DISPOSITION	(Name of	- DATE: 200 LO	CATION CIN	as Town State		
Page 6 ma il director, p		Complete, cremetor or other (Specify) Complete Manor Memorial Park 1995 Elkton, Maryland									
death.		21. SIGNATURE OF FUNERAL SERVICE LICENS	8. Hicks		22. NAME H10 10 E11	cks Home 1 3 West Sto	for Funeral	ls, P.A			
E TE		23. PART I. Enter the disesses, or com shock, or heart failure. List	plications that caused the de t only one cause on each line	sth. Do i	not enter the	mode of dying, suc	h se cardisc or resp	iratory arrest,	Approximats Interval Between		
F 8 € 5		IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Fatal Ventrular Arrythnia  Minute									
Z 8 = 6			DUE TO (OR AS A CONSE	DUENCE O	F):	1-0	· A		11 70		
e be executivities and control to burial traumatic	NO.	Sequentially list conditions, If any, isading to immediate  DUE TO (OR AS A CONSEQUENCE OF):									
te be sician prior t	CAT	cause. Enter UNDERLYING									
h certificat anding phy Hygiene p or other	ERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	DUENCE O	F):				7-		
death certificate attending physical antal Hygiene print, or other to	CER	d									
the deal y the atti of Menta injury,	i . I	PART II. Other aignificant conditions of		esulting	in the underly	ring ceuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS		
w requires that the been signed by the pt. of Health and A shows any Inj	MEDICAL	Sugary Co	ΔΑ				PERFOR		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
requires een sign of Healt		Early Somen	lia		· le		_		1 _ YES 2 _ NO		
law lept 23	AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL			N (Check only o	UNCERTAIN	10		3.4		
N: The law icate has b State Dept.	SICI	EXAMINER?	OSPITAL:  Inpatient 2 ER/Outpatient 3		OTHER:	.,					
PHYSICIAN: The this certificate with the State	PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c.	INJURY AT	28d. DESCRIBE NOW I	NJURY OCCURE	:D		
OING PHYS After this of death with	BY F	1 Netural 5 Pending 2 Accident Investigation	(MORRIL, Day, India)	ING		WORK?  YES 2 NO					
TTENOI TOR: A after d	COMPLETED 8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At ho building, atc. (Specify)	me, 1arm, :	street, factory, o	ffice	281. LOCATION (Street I City or Town, State)	and Number or Re	ural Route Number,		
Se Pin Pin	PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL	Y: To the best of my knowledge, de	ath occum	ed et the time, d	ate and place, end due	to the cause(a) and mar	nner as stated.			
HOSPITAL FUNERAL WITHIN 72 h	MO		in the beals of examination and/or i						use(a) end manner as stated.		
THE HOSPI TO THE FUNER OF filed within	ш	296. SIGNATURE AND TITLE OF CENTIFIER	1. 1			29c. LICENSE NUN	IBER	29d. DATE SIG	GNED (Month, Day, Year)		
6 6 8 M	6	1× Pu	Mr			130:	291	▶ 6	15/95		

M.D. - 111 West High Street - Elkton, MD

Julia d'Awalen Radall

21921

Robert Denitzio, 31. DATE FRED (Month, Day, Year) JUN 0 7 1995

BALTIMORE, MARYLAND 21215-0020

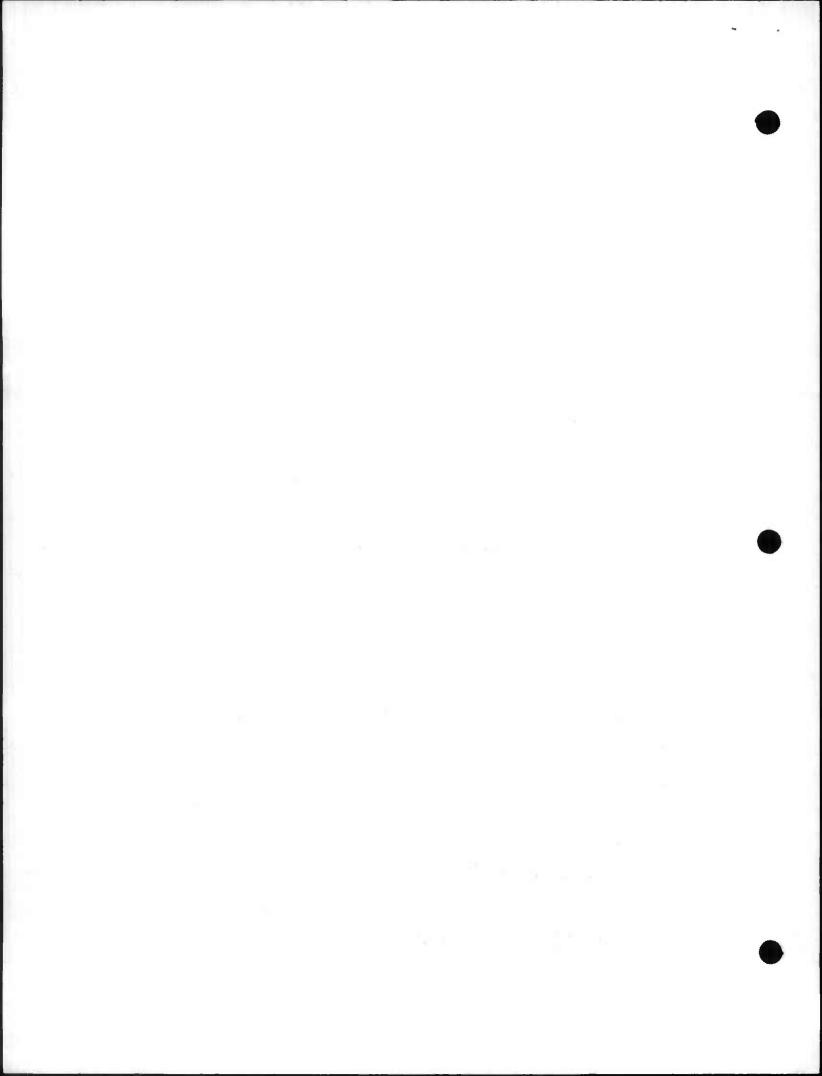
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be detached for use as the bunal-transit permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 8	1. OECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME OF DEATH																
	Franklin James Baker Jr. June 10, May 1995 YEAR 2:25 A.												2:25 A. M				
	4. SOCIAL SECURITY NUMB	4. SOCIAL SECURITY NUMBER			in yrs. last b	birthday) IF I	IF UNDER 1 YEAR		24 HRS.	7 DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign				
1	220-78-0219	9	1 🔀 M 2 🗆 F		25 YRS.		THS DAYS	HOURE	MIN.	Apr. 2, 1	970	Md					
	9a. FACILITY NAME (If not institution, give street and number)					9b.	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNT										
2	Rt. 17						Myersville				Frederick						
15	RESIDENCE OF DECEDENT										1100011011						
DIRECTOR	Md. Frederick					10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?					
						Middletown							1 - YES 2 NO				
₹	10e. STREET AND NUMBER		101. ZIP CODE				10g. CITIZEN OF WHAT										
FUNERAL	8217 Old		21769			769			U.S.	Α.							
1 5	11. MARITAL STATUS  1 ☑ Never Merried  1 ☑ Never Merried  1 ☑ Never Merried				U.S. ARMI	ED	13. WAS DE	CENDENT O	F NISPANI	IC ORIGIN? (Specify Yes or No. 1		14. RACI	E — American Indian, k, Whita, etc.				
BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DA												hite				
ED 6	16 DEC	EDENT'S EDI	ICATION		40. DE00	OFALTIO LIGHT				E Communication	l l		inte				
1 !!	(Specify only highest grade completed)					n. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)				security officer					college							
S S	17. FATHER'S NAME (First, Middle, Last)																
	Franklin James Baker Sr.					Regina D. Michael											
B						MAIL ING ADD	LING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
유	Regina D. Baker						Boileau Ct., Middletown, Md. 21769										
3	20e. METHOD OF DISPOSITI	ON	· · · · · · · · · · · · · · · · · · ·	20b.	_						CATION —		nun State				
	XIX Burial 2 D Cremation 4 Donation 5 D Other		noval from State	Ren	etery, crema	atory or other p	ted Me	tery	ict								
	21. SIGNATURE OF FUNERAL SERVICE SICENSEE						of Disposition   City or Town, Stata   20c. LOCATION - City or Town, S										
	1 1000 5 /11 2 w/5						Donald B. Thompson Funeral Home										
$\vdash$	31 E. Main St., Middletown, Md. 21769																
	23. PART is finite the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate ehock, or heart failure. List only one cause on sech line.  Approximate interval Between																
	IMMEDIATE CAUSE (Finel										Onset and Death						
	disease or condition a. MULTIPLE TRAUMA  BULTIPLE TRAUMA  MIGHT OF AS A CONSEQUENCE OF:												Migutes				
			DUE TO	(OR AS A	CONSEOU	IENCE OF):											
NO	Sequentielly list conditions,																
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING																
등	CAUSE (Disease or Injury 6.																
E	that initiated eventa resulting in deeth) LAS	r 🖟 .		,													
		-	d														
AP.	PART II. Other algnifica	ut not rec	ulting in the underlying ceuse given in			Part I. 24e. WAS AN		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO								
MEDICAL										1 YES 2		1	COMPLETION OF CAUSE OF DEATH?				
H H													1 YES 2 NO				
. Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO																
I K	25. WAS CASE REFERRED TO EXAMINER?							LACE OF D	EATN (Chec	ck only one)							
S	1 X YES 2 NO		HOSPITAL:	ER/Outpu	atient 3		HER: Nursing Hor	ne 5 🗆 Re	sidence 8	Other (Specify)							
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE Of (Month, L			28b. TIME OF	28c. IN	JURY AT	_	28d. DESCRIBE HOW I	NJURY OC	CURED					
BY F	1 Natural 5 2 Accident	795	0156AM 1 TES 2 X NO				THROWN F	ROM	Au	TOMOBILE							
ED E	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, arts. (Specify)									281. LOCATION (Street a							
ETE	4 Homicide determined ROUTE 17 MYERSVILLE DAWN CT MYERSUILLE Md																
	4 Hometon		7 7 5	290. CERTIFIER													
PLE	20a CESTIFIES	IFYING PHYS			edge, deat	h occurred at	the time, date	end place,	and due t	o the cause(e) and mer	ner as ats	ted.					
OMPLE	290. CERTIFIER (Check only		ICIAN: To the best of	my knowle									s) end manner as atated.				
COMPL	290. CERTIFIER (Check only	CAL EXAMINE	ICIAN: To the best of	my knowle				death occur	ed at the ti	ime, data and place, an	d due to ti	ne cause(i					
BE COMPL	29e. CERTIFIER (Check only one) 1 CERT MEDI	CAL EXAMINE	ICIAN: To the best of	my knowle	end/or Inv	restigation, in	my opinion,	29c. LICE	ed at the t	ime, data and place, an	d dua to ti	E SIGNED	(Month, Day, Year)				
COMPL	29e. CERTIFIER (Check only one) 1 CERT MEDI	OF CERTIFIE	ER: On the best of e	my knowle	end/or Inv	restigation, in	my opinion,	29c. LICE	ed at the t	ime, data and place, an	d dua to ti	E SIGNED	(Month, Day, Year)				
BE COMPL	29e. CERTIFIER (Check only one) 1 CERT (Check only one) 2 M MEDI 29b. SIGNATUSE AND TITLE ROLL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF T	OF CERTIFIE	R R R R	my knowle	end/or Inv	restigation, in	my opinion,	29c. LICE	ed at the t	ime, data and place, an	d dua to ti	E SIGNED	(Month, Day, Year)				
BE COMPL	29e. CERTIFIER (Check only one) 1 CERT (Check only one) 2 M MEDI 29b. SIGNATUSE AND TITLE ROLL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF T	OF CERTIFIE PERSON WITH THE PE	ER: On the best of a R R R R R R R R R R R R R R R R R R	my knowled by amination of the party of the	ATN (ITEM:	restigation, in  27) (Type, Print  7	my opinion,	29c. LICE	ed at the t	ime, data and place, an	d dua to ti	E SIGNED					

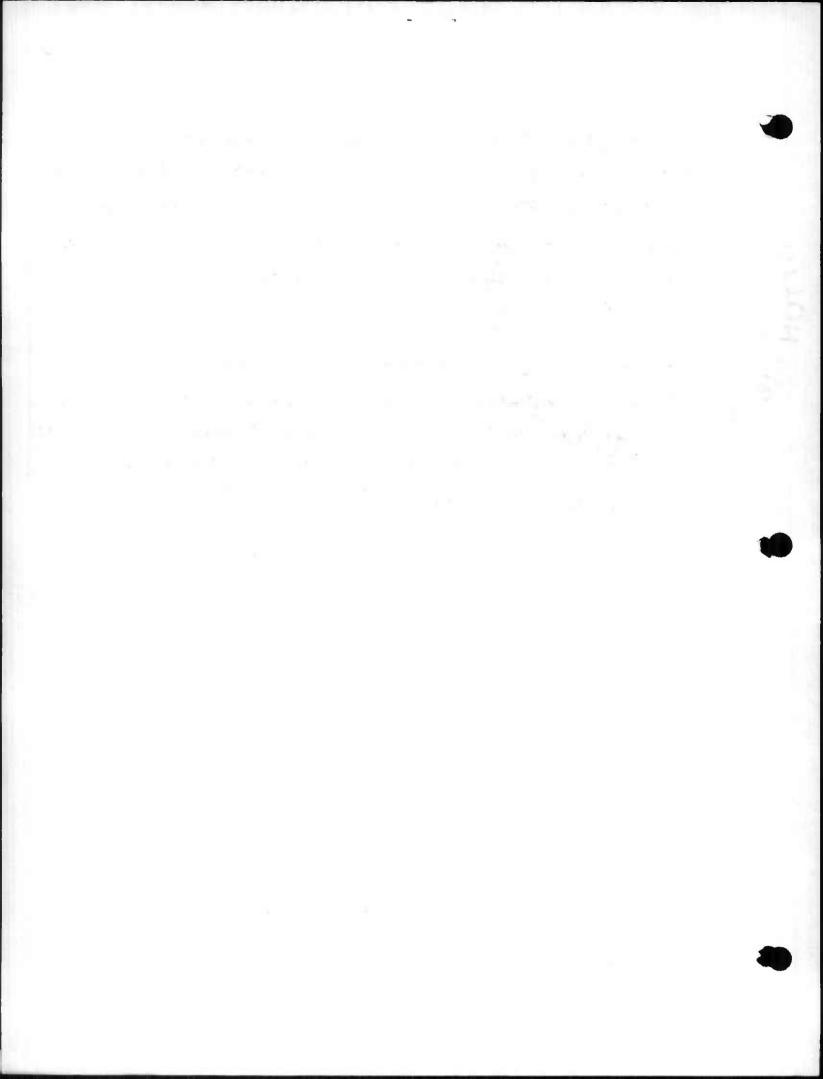


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fourth of the control of the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should him famed within 72 hours after death with the State Debt. of Mealth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL	TO THE FUNERAL	IMPORTANT: H

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
)	1. DECEDENT'S NAME (First, Middle, Last)  CEORGE EOWARD SILVER BAYLESS SH  2. DATE OF DEATH MONTH DAY YEAR 6:15 PM							
ĺ	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1F UNDER 1 YEAR 1F UNDER 1 YEAR 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 24 HRS. 1F UNDER 25 HRS. 1F UNDER 25 HRS. 1F UNDER 26							
	2/2-16-2438 1 XM 2 F 72 YRS. MONTHS DAYS HOURS MIN. J4N2 1 1923 MARY LAND  9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH							
TOR	3574 CHYRCH ROAD ELLICOTT CITY, MO. HOWARD							
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY							
	MO HOWARD BLLICOTT CITY  109. CITIZEN OF WHAT COUNTRY?							
FUNERAL	3574 CHURCH ROAD  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S., ARMED  13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yee or No.   14. RACE - American Indian,							
BY FU	1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)  Black, White, etc.  1 YES 2 NO Specify:  Specify:							
	18. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY							
LETI	(Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4 or 5+)   FARMER   FAMILY FARM							
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)  18. MOTHER'S NAME (First, Middle, Melden Surmeme)							
BE C	GEORGE EDWARD SILVER BAYLESS CORINNE TALBOTT CLARK  19e. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
5	MATIL OA JONES BAYLESS 3574 CHURCH ROAD, ELLICOTT CITY MO. 2043							
	20e. METNOD OF DISPOSITION  1 Darriel 2 Occumention 3 Removal from State  4 Donation 6 Other (Specify)  20b. PLACE OF DISPOSITION (Name of cametary, crematory or other place)  NETRO CREMATORY INC.  CATONSULLE MO							
	21. SIGNATURE OF TUNERAL SERVICE RICENSEE  22. NAME AND ADDRESS OF FACILITY  JOSEPH L. CANBY L.F.D.  3.1784							
	In hu Clar L.F.O. 567 DEER HILL ROAD SYMESUILLE, MD							
	23. PARTY Enter the diseases, or complications the caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory erreat, interval Between Onset and Death  IMMEDIATE CAUSE (Final							
	diseble or condition resulting in death) . a alcano car cenerul lung 2-mos,							
z	DUE TO (OR AS A CONSEQUENCE OF):							
ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING							
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):  Tresulting in death) LAST							
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS							
MEDICAL	Cherous districted pulmons district of completion of cause of personners and the pulmons of completion of cause of personners.							
	1 U YES 2 U NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
IYSIC	EXAMINER?  1 YES 2 NO  1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify)  27. MANNER OF DEATH  28a. DATE OF INJURY  28b. T&ME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							
ВУ РН	1 Netural 5 Pending (Month, Dey, Year) 266. INVEST   Very North All WORK?  1 Netural 1 YES 2 NO							
ED	3 Suicide 6 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or lown, State)							
COMPLET	29e. CERTIFIER (Check only  CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated.							
COM	one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) and menner as stated.							
) BE	296. SIGNATURE AND TITLE OF CERTIFIED (Month, Day, Year)  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, Year)							
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Dr. ALAH G. STAHL M.D., 480-1 Dorsey H. H. II Dr. Ellis att C. S. M.D. DIA 47							
	31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE  1111 1 5 1005							
	JUN 1 5 1995 Julia direction restall							





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

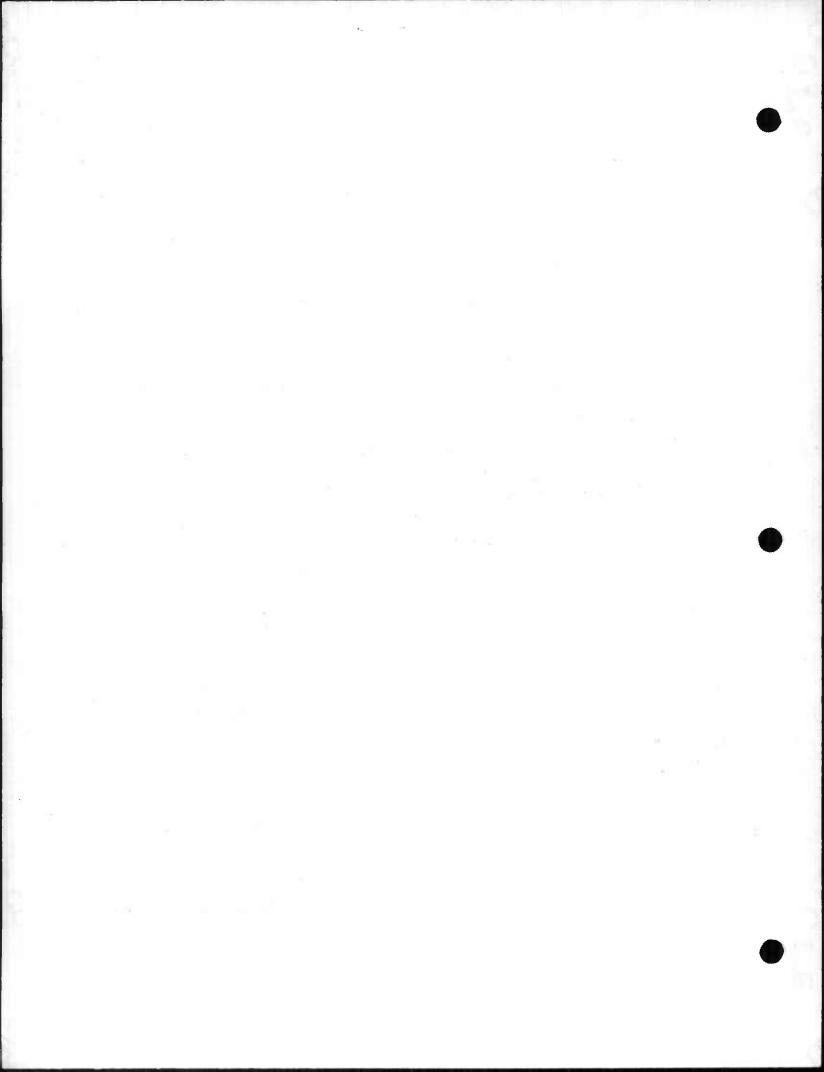
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AV VE	3. TIME OF DEATH		
			TINGER			JUNE 0	9, 199			
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.1	BIRTNPLACE (State or Foreign Country)		
	214-62-4165	1 M 2 □ F	40 YRS.	aon na	HOURS WIN.	Dec. 12,		laryland		
~	9e. FACILITY NAME (If not institution, give st				OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH		
DIRECTOR	GARRETT COUNTY	MEMORIAL	HOSPITAL	OAKLA	ND		GARE	RETT		
ក្ព	RESIDENCE OF DECEDENT  10e, STATE 10b, COUNTY	/	100 CITY	TOWN OR LOCA	TION					
<u>E</u>	MD G	arrett	100.011,	TOWN ON LOCA	0akla	ind		10d. INSIDE CITY LIMITS?		
1	10e, STREET AND NUMBER	arrece		14	M. ZIP CODE		T	1 YES 2 NO		
FUNERAL					21550	<b>\</b>	. 44.6	OF WHAT COUNTRY?		
N N	1014 Hutton Road	12. WAS DECEDENT EVER	IN II C ADMED	12 340 05		NIC ORIGIN? (Specify Yes		USA		
	1 Never Married 2 Married	FORCES? 1 X YE	S 2 NO	If yes, s	pecify Cuban, Mexica S 2 XNO Specific	in, Puerto Rican, etc.)	) or No.— 14.	RACE — American Indian, Black, White, atc.		
ВУ	3 Widowed 4 Divorced	Viet Nam		1 L YES	Specify: White					
ED	15. DECEDENT'S EDUC (Specify only highest grade		16m. DECEDENT'S U	ISUAL OCCUPATI ork done during m	ION	16b. KIND OF BU	SINESS/INDUST	TRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	retired.)						
MP	12		Landso	aper		Lands	scaping			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTNER'S NA	ME (First, Middle, Melden	Surneme)				
BE	McKinley Reub	e Bitti			Genevieve Margaret Bitting					
10	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow				
-	Karen J. Bittinge	r	1014 F	lutton	Road, Oak	cland, Mary	land	21550		
	20a. METNOD OF DISPOSITION  1 M Buriel 2 Cremetion 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece).									
Bittinger Family Cem. 6/13 Swanton, MD								MD		
1 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			NO ACCRESS OF FA					
	Brother H-	Steward				St., Oakl	and, MI	D 21550		
	23. PART i. Entar the diseases, or o	omplications that caus	ed the death. Do no							
	shock, or heart failure. I							Interval Batween Onset and Death		
	disease or condition reaulting in death)	Hem	perila	odiu	n			Sudden		
	Touthing in caucity	DUE TO (OR AS	A CONSEQUENCE OF		Λ	Anou		badden		
Z	Samuradalla Nationalda a Ci	. Kupture	d. Diss	ecting	Hurhe	. Hneu	rysm	Sudden		
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE OF):	. 0						
15	CAUSE. Enter UNDERLYING CAUSE (Disease or injury	h DUE TO COR AC	A COMPTONIENDE OF							
崑	that initiated events  DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST									
		s								
	PART ii. Other significant conditions	s contributing to death	but not reaulting in	the underlyin	g cause given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS		
DICAL						PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE		
MEC										
	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YES	□ NO □	UNCERTAIL	VEX	- 1	74.0 18.10		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATN							
SIC	XYES 2 □ NO	HOSPITAL: 1 ☐ Inpatient 2 X ER/Ou		OTHER:	ne 5 🗆 Residence	8 Other (Specify)				
1	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	Y 28b. TIME	OF 28c. IN.	JURY AT	28d. DESCRIBE NOW I	NJURY OCCURE	ED		
ВУ	1 Natural 5 Pending 2 Accident Investigation	(maxing pay, road)	, , , , , , , , , , , , , , , , , , , ,		YES 2 NO					
ED E	3 Suicide 8 Could not be	28e. PLACE OF INJUI building, etc. (Sc	RY — At home, farm, str	eet, fectory, offic	20	28f. LOCATION (Street a City or Town, State)	and Number or R	Rural Route Number,		
ETE	4 Nomicide determined					Only or lowing Sienes				
12	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my kno	owledge, death occurred	at the time, date	end place, and due	to the cause(e) end man	iner se stated.			
COMPL								use(s) and manner as stated.		
Ü	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			GNED (Month, Day, Year)		
0	Donne	SI Ch	ut p ho		O.C.M.			E 10,1995		
유	30. NAME AND ADDRESS OF PERSON WHO	-		Print)				7.1.2.2		
1	Dennis J. Chute,	0			t, Balt	imore, M	aryla	nd 21201		
	31. DATE FILED (Month, Day, Year)	32_REGISTRAR'S SIG	SNATURE		-					
1 1	JUN 1 4 1995	Julia Structe	ar Rarbell :							



VEAR

3. TIME OF DEATH

6:25

PM

DHMH-16 Rev 1/89

2. DATE OF DEATH DAY

1995

June 3,

BALTIMORE, MARYLAND 21215-0020

FOR

1 -

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Lynwood

5. SEX

Combs,

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BOX 68760,	
P.O.	
RECORDS,	
F VITAL	
VISION O	
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4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 X M 2 | F 264-16-5848 YRS Aug. 26, 1920 Georgia page 5 should be detached for use as the burial-transit permit. Pages 1, 2. 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fairland Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2101 Fairland Road 20904 United States urs after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2X NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 3 Widowed 4 Divorced World War II, Korea White COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5 +) 1 Officer Military 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 76 Andy Lynwood Combs, Sr. Odia Beatrice Adams notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Marion A. McBride 13002 Vandalia Drive, Rockville, Maryland 20853 ě 20e. METHOD OF DISPOSITION
1X Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of cometery, cremetery, cremetery, cremetery or other place)

Quantico National Cemetery

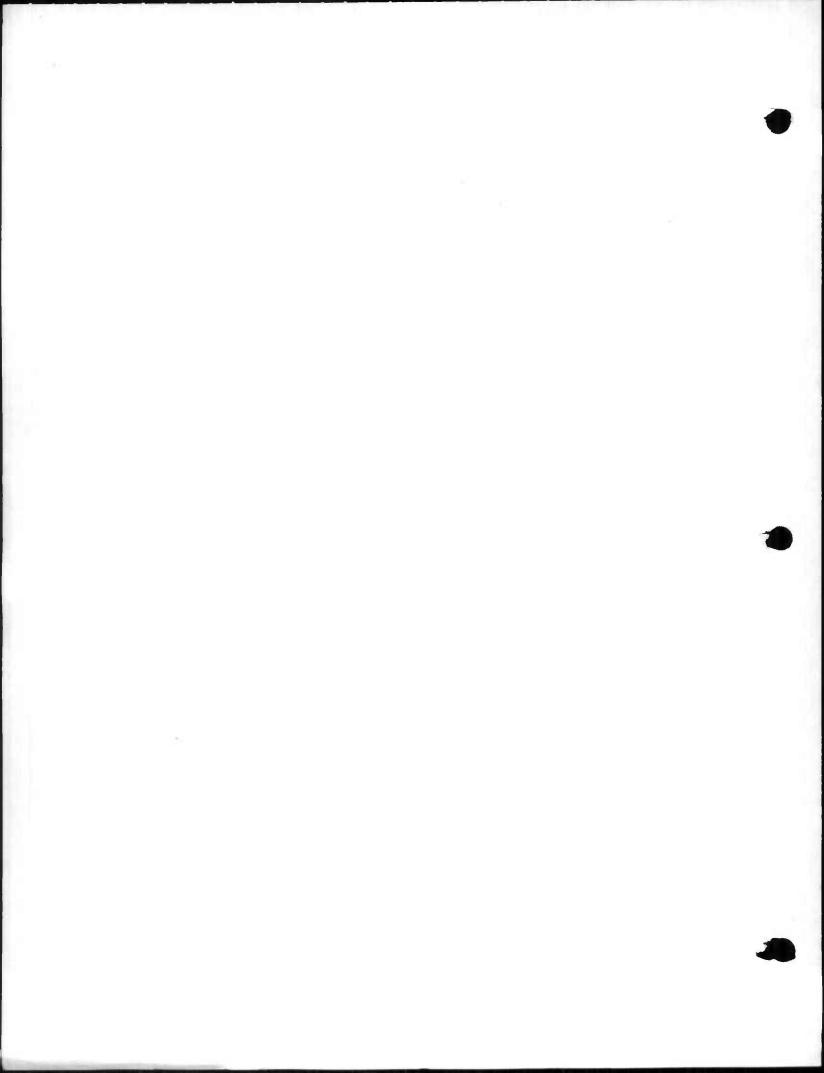
Triangle, Virgin must filled in by the funeral director, ion, or removal. Triangle, Virginia medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Barbard awhence 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failura. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onest and Death and completely fille burial, cremation, the disease or condition CONGESTIVE HEART FAILURE other traumatic event, resulting in dasth) executed CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician a Health and Mental Hygiene prior to if sny, lasding to immadiate csuse. Entar UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 any Injury. PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC USSTRUCTUE LUNG DISCASE MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 23 shows OF DEATH? 1 TYES 2 TIMO DIRECTOR: After this certificate has been hours after death with the State Dept. of PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL Item 2 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
4 Nursing Home 5 Realdence 6 Other (Specify) 1 YES 2 THO ☐ Inpatient 2 ☐ ER/Outpetlant 3 ☐ DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? Is marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) COMPLETED 6 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 4 Homicide Hem 29e. CERTIFIER
(Check only
1 [CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho 2 \_\_ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER mil 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Morgth, Day, Year) 124997 6/3/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LUIS A. CASAS MI) 8317 CHERRY LANE LAURE MD 20707 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JUN 08 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Jr.



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

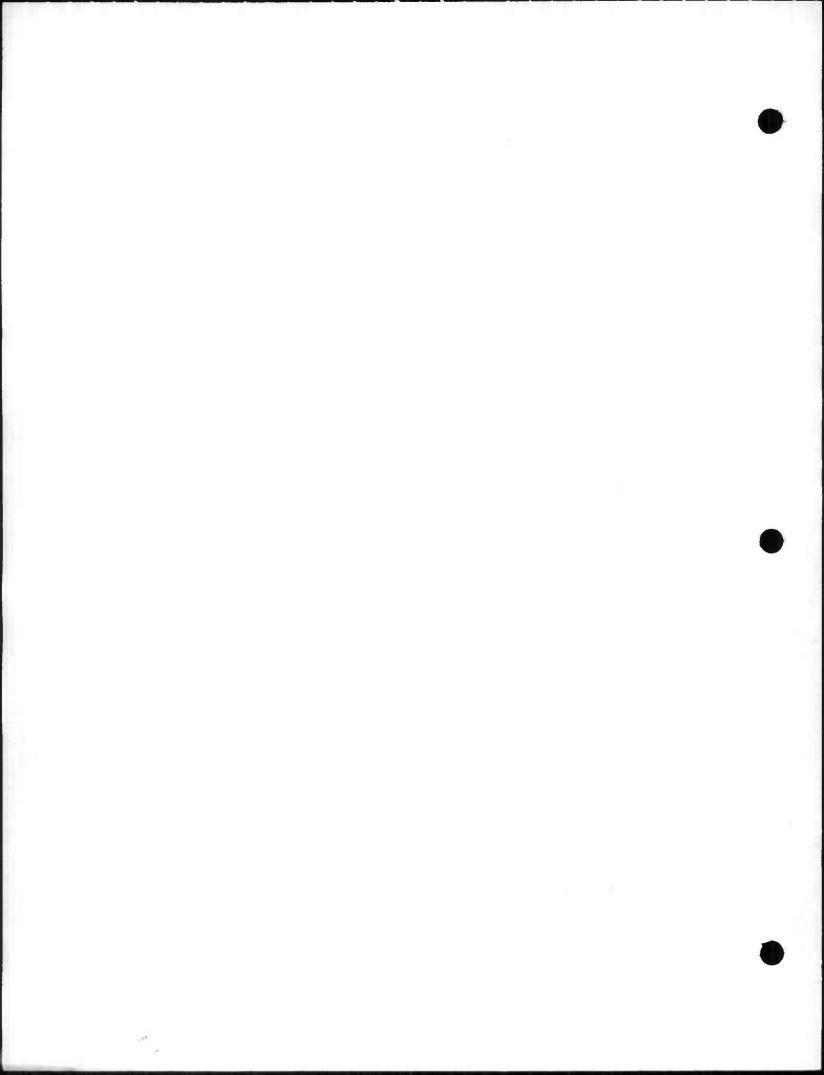
FOR STATE OF MARYLAN REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		C	ERTIF	ICATE	OF	DEATH		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)							MONTH			YEAR	3. TIME OF DEATH
i		Donald 1						June	- /	.995		10:10 A
	4. SOCIAL SECURITY NUMBER 214-36-3169	5. SEX 6	AGE (In yrs. le 98	et birthday) YRS.	MONTHS	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	1	Day, Year)	006	Count	
	Se. FACILITY NAME (If not institution, give a	treet end number)			9b. CITY, 1	TOWN C	R LOCATION OF D		6, 1		Ma.	ryland
OR	Carriage Hill-Bet	hesda					thesda			10000		gomery
<u>ا</u> تا	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY	,		T						_		
DIRECTOR		ntgomery			r, town on etheso		ION					10d, INSIDE CITY LIMITS? 1 YES 2 NO
7	10e. STREET AND NUMBER					101	ZIP CODE			10g, CI1	rizen of	WHAT COUNTRY?
FUNERAL	4409 Highlan						20814					States
BY FU	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1 X IF YES, GIVE WAR	YES 2 OR DATES	NO I	H t	yes, spi	ENDENT OF NISPAR city Cuben, Mexica 2 1 NO Specifi	en, Puerto R		or No-	14. RACI Blac Spec	•
	15. DECEDENT'S EDUC	CATION	16a DI	CEDENT'S	IISHAL OCC	HIDATIC	A1	400	VIII AT 111		1	White
<u> </u>	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  Elementary/Secondary (0-12)						it of working	100.	KIND OF BUS	SINESS/IN	DUSTRY	
ا ټ	Elementary/Secondary (0-12)		ant to the Director   Veteran's Administra						istration			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		ASS.	LStan	1 10	CHE	18. MOTHER'S NA				.CINITI	ISCIACION
									e Wyan			
BE	19a. INFORMANT'S NAME (Type/Print)	b. MAILING	ADDRESS (	Street e	nd Number or Rural		-		in Codel			
۱ ۹	Irene L. Cost					Avenue,					d 20814	
	20b. METNOD OF DISPOSITION    MC   Specify   2   Cremetion 3   Removal from State   20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory, cremetory, or other place)   Cremetory   20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory, cremetory, cremetory, cremetory, or other place)   Rose Hill Cemetery June 8, 1995   Hagerston   199											
- 1	4 Donation 5 Other (Specify)	ENGEE /	Rose	HITT	Ceme	ter	y June 8	3, 199	Hage	ersto	wn,	Maryland
	22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Bett Chevy Chase, Inc., 7557 Wisconsin A. Bethesda, Maryland 20814-3501								Bethesda- n Avenue			
	23. PART i Enter the diseases, or o	complications that c	eused the de	eath. Do n	ot enter th	he mo	de of dying, suc	h as cerdi	ac or respi	ratory as	reat,	Approximata
	shock, or heart failure.	List only the cause	on aach line	<b>.</b>								Interval Between Onset and Deati
	disease or condition									Oliset and Death		
	resulting in death)	n. Congest:	R AS A CONSE	OUENCE OF	allur D	e						
z		b										İ
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSE	OUENCE OF	ን:							
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	c										
	that initiated events resulting in death) LAST	OUE TO (OI	R AS A CONSE	OUENCE OF	7):							
Į ļ		d										
	PART il. Other algnificent condition	a contributing to de	eth but not	resulting i	n the unde	eriying	ceuse given in	Part I.	24a. WAS AN		246	. WERE AUTOPSY FINDINGS
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 123 2		Ì	OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAU	SE OF DEA	TH YE	s П N	οП	UNCERTAIL	ΝП				To res 1 Xno
3	25. WAS CASE REFERRED TO MEDICAL				H (Check on		0.102.1.0 1.0					
2	EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpetient 2   E	R/Outpatient 3	DOA	OTHER:	o Hom	5 Residence	6 Other	(Specify)			
PHYSICIAN: M	27. MANNER OF DEATH	28a. OATE OF IN	JURY	28b. TIMI	E OF 2	Sc. INJU	JRY AT		RIBE NOW I	NJURY OC	CUREO	
	1 Natural 5 Pending Investigation	(Month, Day,	Year)	INJ		1   Y	RK? ES 2 NO					
0	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF I	NJURY — At ho	rme, farm, s	treet, factor	y, office		28f. LOCA	TION (Street e	nd Numbe	r or Rural I	Route Number,
U	4 Homicide determined	building, etc	: (Specify)					City o	Town, Stete)			
2	29e. CERTIFIER 1 X CERTIFYING PNYSH	CIAN: To the best of my	knowledge, de	eth occurre	d at the time	e, date	end place, and due	to the caus	e(e) end man	mer ee ata	rted.	
COMPLE	one) 2 MEDICAL EXAMINE											e) and manner as stated.
5	296. SACHATUM AND TITLE OF CERTIFIES						39c. LICENSE NUM					(Month, Day, Year)
ןן מ	1600 10. (10	um to	> /	mp			021	115				6,1995
2	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITE	М 27) (Тура,	Print)			, 7			~***	0,2000
	Lee R. Pennington					те,	Bethesda	a, Ma	ryland	i 20	0817	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S										
	JUN 08 1995 Julia Standar Parl 11											

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DHMH-16 Rev 1/89



Pages 1, 2, 3

permit.

completely filled in by the funeral director, page 5 should be detached for use as the burial-transit rial, cremation, or removal. notified hours after death. the traumatic event, and com o burial, attending physician a intal Hygiene prior to other t the aften Mental I 23 shows any Injury, signed by the certificate has been in the State Dept. of the 0 with t Is marked, After t DIRECTOR: / 28 item TO THE FUNERAL OF TO THE FUNERAL DE FINE WITHIN 72 ho

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31. DATE FILED (Month, Day, Year)

JUN

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH **JEAN ELIZABETH** THOITS COOLIDGE June 1. 1995 12:00 P 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 - M 24 X F 551-28-7152 81 Sept.27, 1913 California 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5423 Mohican Road Bethesda Montgomery 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery 1 YES 2 X NO Bethesda 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5423 Mohican Road 20816 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES XXNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES XXNO Specify: 14. RACE — American indian, Black, White, etc. 1 Never Merried 2XXMerried ВY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) 75 Willis C. Thoits BE Hazel A. Lamson 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 William B. Coolidge 5423 Mohican Road, Bethesda, MD pe 20e. METHOD OF DISPOSITION
1 Duriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Chesapeake Crematory 6-3 Beltsville, MD 21. SIGNATURE OF FUNERAL SERVICE LICEN examiner 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A. M00827 933 Gist Ave. Silver Spring, MD 20910 medical 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition multipline neo my) reaulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 - YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER**? HOSPITAL: OTHER:
4 □ Nursing Home XXReeldence 6 □ Other (Specify) 1 YES XXNO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, INJURY AT 28d. OEŞCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO ВУ 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be datermined COMPLETED 4 Homicide 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. 29b. SIGNATURE/AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month Day Year)

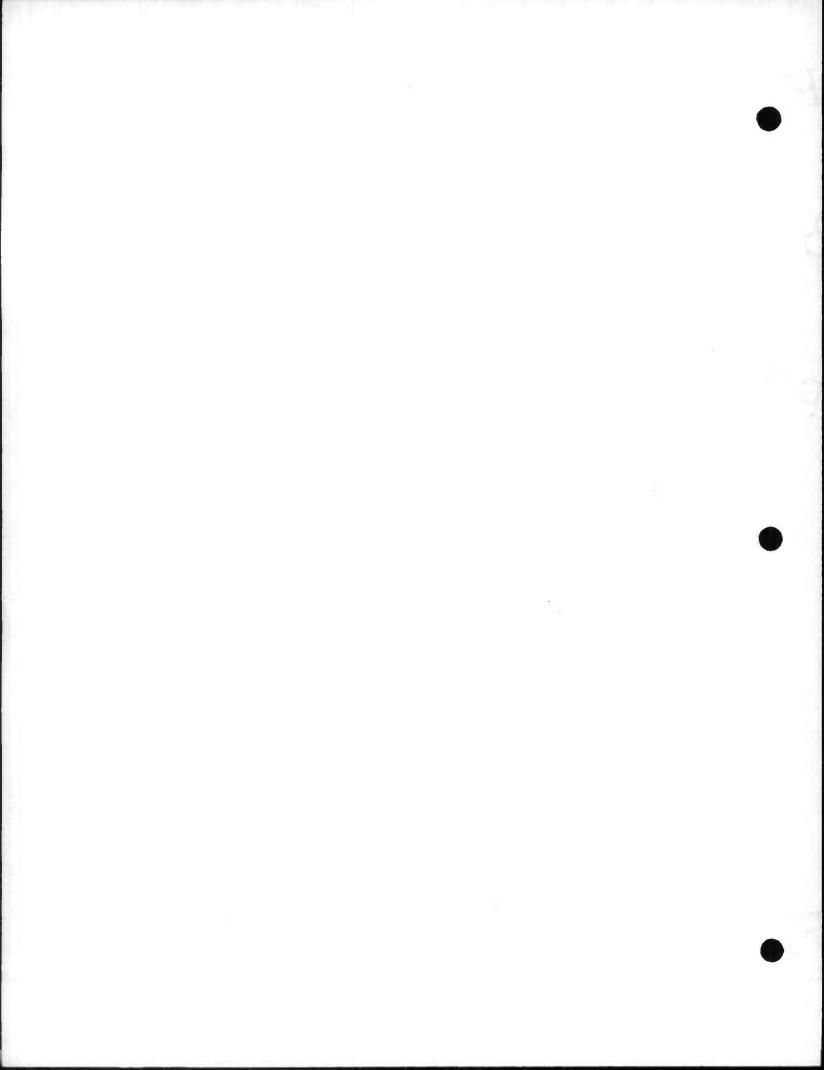
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Devra C. Marcus, MD 1145- 19th Street, NW #600 Washington, D.C. 21 32 ASCHISTIAN'S SCHATTONE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Marcu-

June 2, 1995



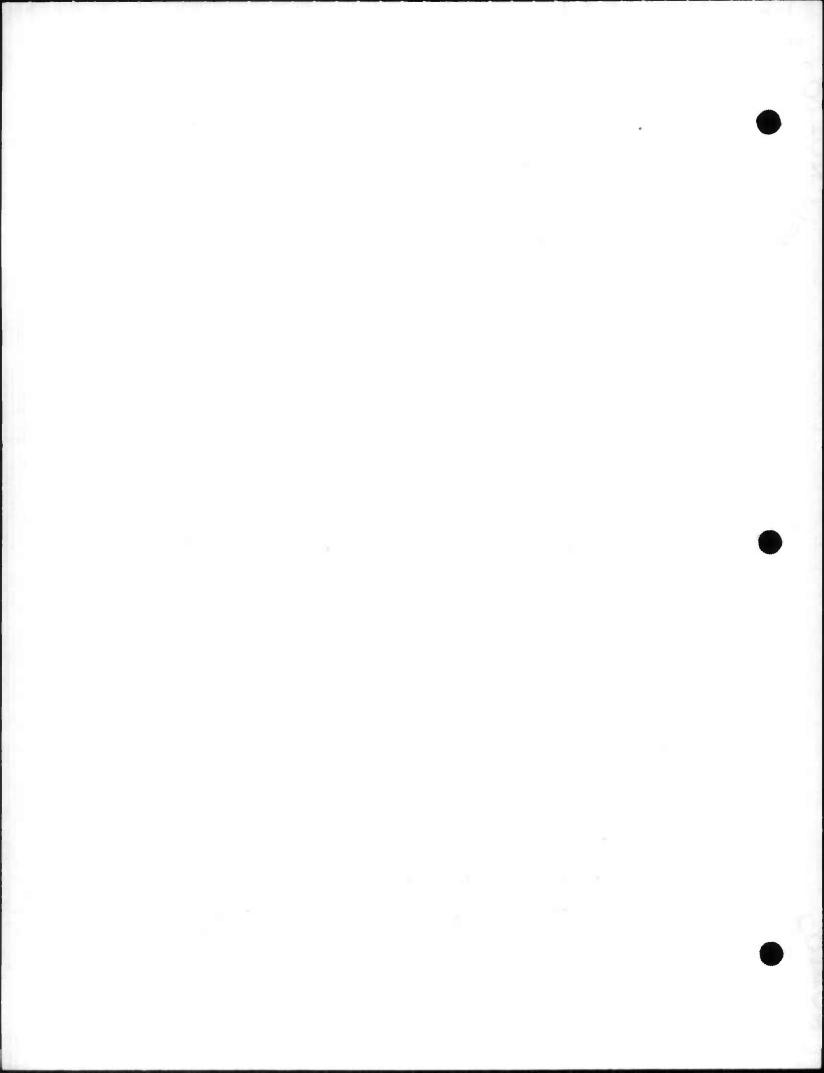
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BALTIMORE, MARYLAND 21215-0020	ir death. Page 6 may be retained by the hospital or attending physician.
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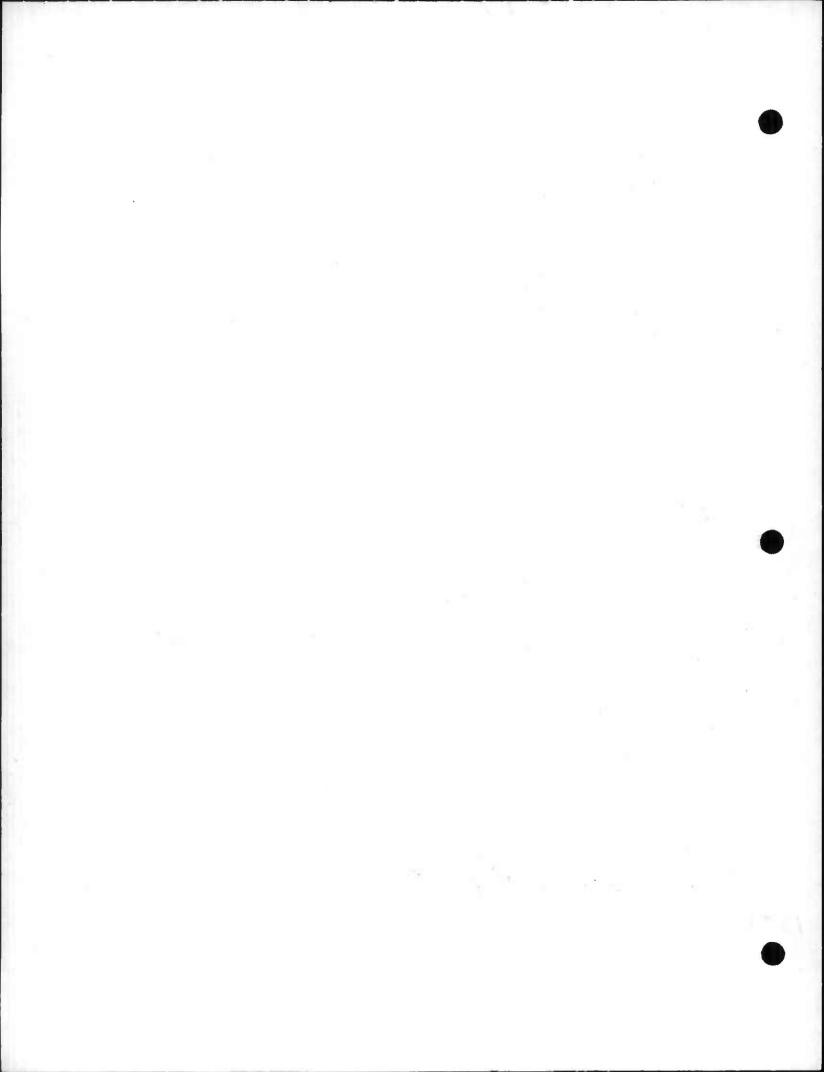
r death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fill be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	. HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPARTM CERTIFIC	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	LUVANT	4 .	119, JR.	2. DATE OF DEATH PONTH DAY	995	3. TIME OF DEATH 829P M		
	4. SOCIAL SECURITY NUMBER 219-07-3183  90. FACILITY NAME (If not institution, give s	1 K M 2 - F	82 YRS. MOR	UNDER YEAR IF UNDER 24 HRS. THIS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 18, 19	12 Vir	ginia		
TOR	Laurel Regional			city, town or location of D Laurel		Prince			
DIRECTOR		y gomery		wn or Location tonsville			10d, INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	4307 Sandy Sprin	0		101. ZIP CODE 20866		g. CITIZEN OF W Inited S			
B⊀	11. MARITAL STATUS 1 Never Married 2 XXMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	S 2X XNO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico 1 YES 2 NO Specific	in, Puerto Rican, etc.)	No- 14. RACE Black Specif	- American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	Cation completed)  College (1-4 or 5 +)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret Carpente	done during most of working ired.)	166. KIND OF BUSINES		stry		
BE COM	17. FATHER'S NAME (First, Middle, Last) Lionel L. Chewni:	ng			ME (First, Middle, Maiden Surne				
TO B	190. INFORMANT'S NAME (Type/Print) Lionel L. Chewni:	ng		RESS (Street and Number or Rural Wer Bridge Dri			and 21122		
	20e. METHOD OF DISPOSITION 1 XI Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of cametery, cremetory or other place) George Washington Cemetery 6/8  Adelphi, Maryland								
	22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MI								
	IMMEDIATE CAUSE (Finel	List only one ceuse on	each line.	offer the mode of dying, such			Approximate Interval Between Onset and Daath		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	с	A CONSEQUENCE OF):  A CONSEQUENCE OF):						
AL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED?  1 YES 2 2 10 0F								
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)								
	27. MANNER OF DEATH  1 Netural 5 Pending	1 TES 2 NO 1 Inpetient 2 PR/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)  27. MANNER OF DEATH  28. THE OF 28. TIME OF 28. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED							
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28e. PLACE OF INJUR building, stc. (Spe	Y — At home, farm, street	, factory, office	281. LOCATION (Street and N City or Town, Stete)	lumber or Rural Ro	oute Number,		
COMPLETED				the time, date and place, and dua my opinion, death occured at the			and manner sa stated.		
TO BE (	296. SIGNATURE AND TITLE OF CENTIFIES  10 NAME AND ADDRESS OF PERSON WAS	Hodingy	SIM	29 CENSE NUI	ABER 299	DATE SIGNED	(Month, Day, Year)		
	31. DATE THER MONTH COM MICH	CANGE WZ	EATH (ITEM 27) (Type, Print	Pay Sum (	4. G Sm.	mu:	8470		



213-24-3476  1	SYLVANIA  EATH  ETY  10d. INSIDE CITY LIMITS?  1 YES 2 NO WHAT COUNTRY?  S. A  — American Indian, White, etc.
Thomas John Clark  4. SOCIAL BECURITY NUMBER  213-24-3476  1	PLACE (State or Foreign )  SYLVANIA EATH  ETY  10d. INSIDE CITY LIMITS?  1 YES 2 NO MAT COUNTRY?  S. A.  — American Indian, White, atc.
4. SOCIAL BECURITY NUMBER 213-24-3476  99. FACILITY NAME (If not institution, pive street and number)  99. FACILITY NAME (If not institution, pive street and number)  109. STATE 109. STAT	Sylvania  EATH  ETY  10d. INSIDE CITY LIMITS?  1 YES 2 NO THAT COUNTRY?  S. A.  — American Indian, White, atc.
99. FACILITY NAME (If not institution, give street and number)  10910 01d Georgetown Road  RESIDENCE OF DECEDENT  109. STATE  109. COUNTY  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  MATYLAND  100. CITY, TOWN OR LOCATION  100. CITY, TOWN OR LOCATION  100. CITY, TOWN OR LOCATION  100. CITY, TOWN OR LOCATION  100. CITY, TOWN OR LOCATION  110. MARITAL STATUS  110.	ery  10d. Inside city Limits?  1 Yes 2 No What Country?  S. A.  — American Indian, White, etc.
10910 Old Georgetown Road    Secondary   Telephone   T	10d. INSIDE CITY LIMITS?  1 YES 2 NO PHAT COUNTRY?  S A  — American Indian, White, atc.
The state of the s	10d. INSIDE CITY LIMITS? 1 YES 2 NO PHAT COUNTRY?  S A  — American Indian, White, atc.
Maryland Howard    Maryland Howard   Mt. Airy	1 YES 2 NO THAT COUNTRY?  S. A  — American Indian, White, atc.
The property of the property o	S.A.  — American Indian, , White, atc.
Specify:    Specify   Spec	— American Indian, , White, atc.
Specify:    Specify   Spec	, White, atc.
To be a property of the proper	te
To be a property of the proper	
The proof of the p	
Joseph Clark    Joseph Clark   Ellen   McDermott	
Joseph Clark    Joseph Clark   Ellen   McDermott	
~ B VI DULL FIL. AITV. MATVIANO	21771
20e. METHOD OF DISPOSITION	
Semantic 2 Cremetton 3 Removed from State    Commettery   Commettery or other place   Commettery	vland
Service   2   Cremation   3   Removed from State   Comparison, crematory or other place   Compar	Tno
Mistoplan Mashburn 500 University Blvd., W. Sil. Spr.	MD 20001
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of duling such as scales as a scale of the scale of th	Approximata
ahock, or heart failure. List only one ceuse on each line.  iMMEDIATE CAUSE (Final disease or condition	Onset and Deat
disease or condition resulting in death)  Acute Diastolic Heart Failure  DUE TO (OR AS A CONSEQUENCE OF):	Immediate
IMMEDIATE CAUSE (Final disease or condition resulting in death)    Acute Diastolic Heart Failure	
resulting in death)  resulting in death)  resulting in death)  resulting in death)  resulting in death)  resulting in death)  Resulting in death)  resulting in death)  Resulting in death death death death death death death death death death	2 Months
X a go b	
CAUSE (Disease or injury that initiated events resulting in death) LAST	+
that initiated events resulting in death) LAST	
The state of the s	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
TO A COUNTRY TO A	OF GEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO NO UNCERTAIN	1 NES 2 NO
A DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 25. Whas Case Reference to Medical 26. Place of Death (Check only one)	
28. PLACE OF DEATH (Check only one)  EXAMINER?  1 VES 2 NO 1 Input lent 2 ER/Outpet lent 3 DOA Check only one)  Wes 2 No 1 Input lent 2 ER/Outpet lent 3 DOA Check only one)	
LL S S T 27 MANNER OF DEATH	
ことを   In ing natural 5   Penging   M I . Communication   M I . C	
Note that the second se	oute Number,
Z Accident Investigation  S Suicide 1 Accident 3 Suicide 2 Could not be determined 1 W State Suicide 3 City or Town, State)  2 Accident 3 Suicide 4 Homicide 6 Could not be determined 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 2 See. PLACE OF INJURY — At home, farm, street, factory, office 3 See.	
2 20 = 1 (Crisco only 24 1 (Cr	
29. CERTIFIER (Check only 1 Check only 2 Li Li Li Li Li Li Li Li Li Li Li Li Li	and manner as stated.
THE LANGE AND THE CONTROL OF CENTREES AND AND THE OF CENTREES AND THE OF CENTREES AND	(Month, Day, Year)
228 <b>≥</b> 0 D 04179 D June 5	, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
James J. Fost x, M.D. 5530 Wisconsin Avenue #925 Chevy Chase Maryland 2  31. Date FileD (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	
JUN 06 1995 Julia Studies Rarlally	0815
JUIN WILLIAM TO 17.5.1	0815



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	TIEGISTIAN			EHIIL	ICAIE	UF	DEAL	П	A	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)  CORAL C.	CALLOW	AY						2. DATE OF I	DA DA		YEAR 995	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		6. AGE (in yrs. le:	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF E	METH	2/ /		PLACE (State or Foreign
	279-16-5106	1 M 2 X F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. Z	y. Year)	1914	Ohi	()
	9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY,	TOWN O	R LOCATIO	ON OF DE				NTY OF DI	EATH
OR	Stella Morris Hos	pice			To	wsor	1				Ва	ltim	ore
딚	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY	,		I 40. 000	Y, TOWN O								
DIRECTOR	Maryland Carro				tmin								10d, INSIDE CITY LIMITS?
4	10e. STREET AND NUMBER	11		WES	CHITH		. ZIP CODE		· · ·		OIT	7511 05 11	1 YES 2 NO
FUNERAL	2375 Coon Club Ro	ad				101.	2115				US		HAT COUNTRY?
<u>N</u>	11. MARITAL STATUS	12. WAS DECEDENT			13. V	AS DEC	ENDENT O	F HISPANI	C ORIGIN? (S	pecify Yes		14. RACE	- American Indian,
	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 (		NO	10	yes, spe	ecity Cubar 2 NO	n, Mexicen	, Puerto Rican	, stc.)		Black Specif	, White, stc.
BY												W	nite
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		(G	CEDENT'S live kind of v	vork done d			g	16b, KIN	O OF BUS	SINESS/INC	DUSTRY	
٦	Elementary/Secondary (0-12) College (1-4 or 5 +)					ict			p.o		C-1		
M	17. FATHER'S NAME (First, Middle, Last)	0		Recep	LIOIL	ISL	10 10071	ED'S NAM	IE (First, Middle		Sal	.on	
	Harry W. Estell  190. INFORMANT'S NAME (Type/Print) Quinton Calloway  200. METHOD OF DISPOSITION  200. PLACEAL								Owens	e, Maksen :	Surname)		
BE					ADDRESS	(Street a			oute Number, C	alty or Town	Stata Zir	Code	
2													nd 21157
					2375 Coon Club Road, Westminst						LOCATION — City or Town, State		
	4 Donation 6 Other (Specify)	over from State	Gate	of He					6/5	Sil-	ver :	Sprin	ng, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1		22. N	AME AN	D ADDRES	S OF FAC	uty Hin	es-R	inal	di Fu	ineral Home
	Laine of	Phu	lens	)	S	ilv	er Si	v nam	npshir g, Mar	e Av	enue d 20	0904	
	23. PART I Enter the diseases, or o	omplications that	caused the de	ath. Do n									Approximata
	shock, or heart fellure.  IMMEDIATE CAUSE (Finel	List only one caus	e on each line										Interval Between Onset and Death
	disease or condition resulting in deeth)	CHRON	IC LY	MPH	100	FTIC	- 1	EU	KEM	IA.			18 mas.
			OR AS A CONSE										
ON	Sequentially list conditions,	DUE TO #	OR AS A CONSE	DUENCE OF	٥.								
TA.	If any, leeding to immediate cause. Enter UNDERLYING	202 10 (	on As A CONSE	ACENCE OF	7.								
CERTIFICATION	CAUSE (Disease or Injury thet initieted events	DUE TO (	OR AS A CONSE	DUENCE OF	ን:								
H	resulting in death) LAST	d											
2	PART II. Other significent condition	s contributing to d	leath but not a	eeulting i	n the une	doglydaa		luin la C	and I am	. WAS AN	***********	Lan	
EDICAL				osumy .	iii die dii	Jerrynng	ceuse g	IVOIT III F		PERFOR	MED?	240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
									_   10	YES 2	NO		OF DEATH?
Σ	DID TOBACCO USE CONTI	RIBLITE TO CAL	ISE OF DEA	TH YE	s $\square$ N	IO X	LINC	ERTAIN					1 YES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL	MOTE TO CAC		E OF DEAT			OIACI	CKIAIIY					
SIC	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		s 5   Res	sidence 6	X Other (Spi	ec/fv)	HOSE	TCE	
PHYSICIAN	27. MANNER OF DEATH	28a. DATE OF II (Month, Day		28b. TIMI	E OF	28c. INJL	JRY AT		28d. DESCRIE				
ВУ	Natural 5 Pending Accident Investigation	(Month, Day	, , , , , , , , , , , , , , , , , , , ,	lino.	M	1 🗌 Y		NO					
											nd Number	or Rural R	oute Number,
4 Homicide determined building, etc. (Specify)													
	4 Homicide determined	building, a											
APLET	4 Homicide detarmined  29a, CERTIFIER (Check only)	CIAN: To the best of n	ny knowledge, de										
COMPLET	4 Homicide determined	CIAN: To the best of n	ny knowledge, de										and manner as stated.
BE COMPLETED	4 Homicide detarmined  29a, CERTIFIER (Check only)	CIAN: To the best of n	ny knowledge, de				ath occure		me, data and		d dua to th	e cause(a)	and manner as stated.
H H	4 Homicide detarmined  29a. CERTIFIER Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER  29b. SIGNATURE AND TITLE OF CERTIFIER  CAGOLOGICAL EXAMINED	CIAN: To the best of n	ny knowledge, de minetion end/or		n, in my op		ath occure	d at the ti	me, data and		d dua to th	e cause(a)	
w II	29a, CERTIFIER (Check only one) 2 MEDICAL EXAMINE  29b, SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	CIAN: To the best of n R: On the best of axe COMPLETED CAUSE	whowledge, demination and/or	M 27) (Type,	n, In my op	inlon, de	29c. LICE	NSE NUME	me, data and BER 4-3	place, and	29d. DATE	e cause(a)	
8	4 Homicide detarmined  29a. CERTIFIER Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER  29b. SIGNATURE AND TITLE OF CERTIFIER  CAGOLOGICAL EXAMINED	CIAN: To the best of n R: On the best of axe COMPLETED CAUSE	w knowledge, de minetion end/or COF DEATH (ITE	M 27) (Type,	n, In my op	inlon, de	29c. LICE	NSE NUME	me, data and BER 4-3	place, and	d dua to th	e cause(a)	

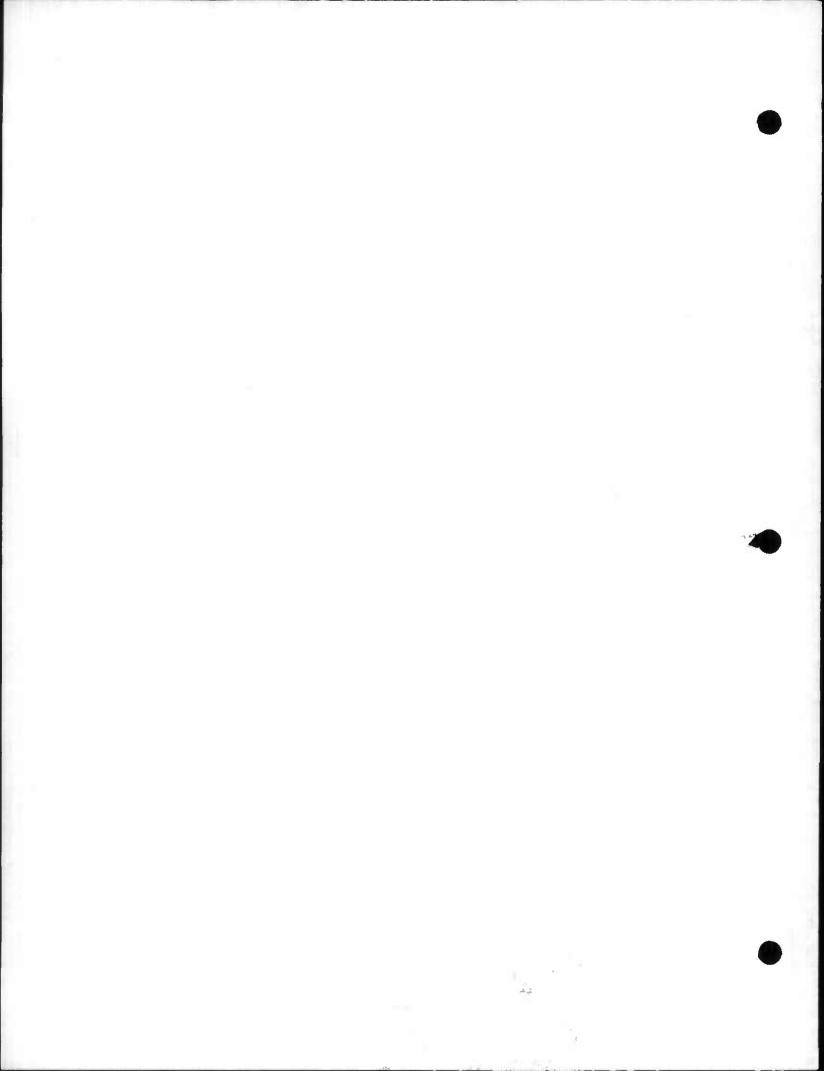
Landa de la companya de la companya de la companya de la companya de la companya de la companya de la companya

BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within frours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

_	nedio man				CENTIF	ICAI	E OF	DEA	l III		REG. NO.				
	1. DECEDENT'S NAME (First,									2. DATE	DF DEATH	/A	YEAR	3. TIME	OF DEATH
	Eula		laureen		Cre	ger					8, 19		LAA	4:	:30 A M
	4. SOCIAL SECURITY NUMB	= I	5. SEX	6. AGE (In yrs	s. last birthday)	IF UNDE	DAYS	IF UNDER	24 HRS.		OF BIRTH h, Day, Year)		a. BIRTH Country	PLACE (S	State or Foreign
	216-44-9760		1 🗆 M 2 🖵 F	88	YRS.						29,19	907	Iow	a	
~	9a. FACILITY NAME (If not in		III SCOOLS W.			9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH	
DIRECTOR	Washington	Advent	<u>ist Hosp</u>	ital		T:	akom	a Par	k	_		Mo	ntgo	mery	1
<u></u>	10a. STATE	10b. COUNTY			10c. CI1	Y, TOWN	OR LOCA	TION						10d, INS	BIDE CITY
5	Maryland	Montg	omerv		S	1776	r Sp	ring							NTS?
FUNERAL	10e. STREET AND NUMBER						-	1. ZIP CODE				10g. CIT	IZEN OF W	-12	
띮	321 Univers	ity Bo	ulevard,	West	#L-6			20	901			II	S.A.		
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S	LS. ARMED 13. WAS DECEMBENT OF HISPANIC OR				IC DRIGII	V? (Specify Yes			— Amer	rican Indian, etc.	
ВУ	1 Never Married 2 3 Widowed 4 Divo			2 X NO			Rican, etc.)		Specif		etc.				
		- 1		1000									Whi	te	
	(Specify only	highest grade of	completed)		Give kind of life. Do NOT u	work done	during me		g	168	. KIND OF BUS	INESS/INC	USTRY		
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5				,					_			
<u>≅</u>	17. FATHER'S NAME (First, Mi	iddle Last)			Bookkee	per		40 14071	IPP/0 4144		deral		rnme	nt	
	Linden F. C											Surname)			
BE	19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRES	S (Street		die		1g ber, City or Town	Chain 7in	Codel		
2	Jayne F. Fr	ies									ville,			207	702
1	20a. METHOD OF DISPOSITI	ON		20b. PLA	CE AND DATE	DE DISBO	SITION (A)	ame of		DAT	E 200 LOV	MONTA	City on To-		
	1 ☐ Buriel 2 🔯 Crematio 4 ☐ Donation 8 ☐ Other		val from State	_ cemetery Metr	opolit	ther place	rem:	atorv	6	19/9	5 Alex	andr	da W	irai	nia
	21. SIGNATURE OF FUNERAL	L SERVICE LICE	ENSEE	1		22	. NAME A	ND ADDRES	S OF FAC	HLITY					
	· m	_/	10.								Funer				
	23. PART I. Enter the di	seeses, or co	omplications the	t caused the	deeth Do	ot ente	JU U1	niver	sity	BIV	d.,W.	Sil.	Spr.		
	ahock, or he	ert fallure. L	iat only one ceu	se on sech	line.	or one		de or dyr	ng, auch	i aa can	arac or reepi	atory arr	eat,	int	oproximata tervai Between
	IMMEDIATE CAUSE (Fin disease or condition	al	Hypovo.	lemic	Shock										neet and Death
ł	reaulting in death)	<b>7</b> .			SEQUENCE O								11	day	
,	Pseudomembranous colitis														
CERTIFICATION	Sequentially ilst conditi- if any, leading to immed				SEQUENCE O								week		
3	cause. Enter UNDERLY!! CAUSE (Disease or injur	NG	Acute 1	Jrinar	y Trac	t In	fect	ion						1	week
	that initiated events				SEDUENCE O										
#	resulting in death) LAS	d	Chronic	ODSE	ructiv	e Lu	ng L	iseas	se					у	ears
	PART II. Other algnification	nt conditions	contributing to	deeth but n	ot resulting	in the u	nderlyin	g ceuse g	lven in F	Part I.	24a, WAS AN	AUTOPSY	24b.	WERE ALI	JTOPSY FINDINGS
EDICAL	Hypertensiv										PERFOR			AWAILABL	LE PRIOR TO TION OF CAUSE
	Dysphagia									-	1   YES 24	AT ND		OF DEAT	
Σ	DID TOBACCO US	SE CONTR	IBUTE TO CA	USE OF D	FATH Y	s $\square$	NO D	LINC	FDTAIN					1   YE	S 2 ND
₹	25. WAS CASE REFERRED TO	-			LACE OF DEA			0110							
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpatien	t 3 🗆 DOA	OTHE		e 5 🗆 Res	sidence 8	B  Othe	r (Snacily)				
美	27. MANNER OF DEATH		28a. DATE OF (Month, D	INJURY	28b. TiM	E OF	28c. IN.	URY AT			CRIBE HOW IN	JURY OCC	CURED		
BY		Pending rivestigation	(MONIN, D	ay, rear/	in.	URY M		YES 2	ND						
	9 Deutstein	Could not be	28e. PLACE O	F INJURY — A	t home, term,	street, lac	tory, offic	•		281. LOC	ATION (Street as or Town, State)	nd Number	or Rural R	oute Num	ber,
	4 Homicide	Setarmined			_					Oily	or lown, State)				
COMPLETED	29a. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the best of	my knowledge	, death occurr	d of the	time, date	and place,	and due t	to the cau	ree(a) and man	ner sa stat	ed.		
8			On the basis of a											and mer	nner as stated.
- 4	296. SIGNATURE AND TITLE	OF CERTIFIER	0					29c. LICE	NSE NUM	HER		29d. DATI	E SIGNED	(Month, D	Day, Year)
BE	Jungs	2	-e-	el.	1			D267	07		ļ		une		, ,
۹ ا	30. NAME AND ADDRESS/OF	PERSON WHO								Perform			OII C	ر و ر	775
	Tung-Pi/Lee	-	7	UU Buc	kingha	ım D	r.,	Silv	er S	prin	ng, MD	209	01		
	31. DATE FILED (Month, Day, )	rbar)	Li Hwels	R'S SANATIN	ħ									_	
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															DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Flours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	he filed within 72 hours after death with the State Dent of Health and Mental Hydiene prior to burial greenation or removal
	SS	SNE	ithic
	EH	E	3
	王	H	file.
	8	8	5

29b. SIGNATURE AND TITLE OF CERTIFIER

David Dunn,

JUN 1 2 1995

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32, REGISTRAR'S SIGNATURE

Jahr Skudson Radal

M.D.

BE

2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 6. JUNE 5:50 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign N' April 1 - M 2 - F 99 YRS. 19,1896 Carolina 218-40-2057 permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bel Air Convalescent Center Bel Air Harford RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Bel Air 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? tending physician. as the bunial-transit 410 E. McPhail Rd 21014 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FUNCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married It yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 TES STENO Specify: BY 3 K Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only his (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL **Hnknown** Farmer Agriculture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ħ Alfred Cox Cora Greer BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Herbert B. Cox 2817 Rocks Rd., Jarrettsville, MD. 21084 pe 20s. METHOD OF DISPOSITION
1 

Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Donation 6 Other (Specify) Gardens 6/13/95 Bel Air, MD Mem 21, SIGNATURE OF BUNERAL SERVICE LICENSEE examiner When Harkins F.H.Inc., Delta, PA., 17314 medical 23. PART I. Enter the diseases, Dr complications that caused the daeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Fine) Onest and Death the disease or condition resulting in death) DUE TO (OR AS A CONSCOUENCE OF): hours event, ztt-1 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate CRUSE Enter UNDERLYING CAUSE (Disease Dr Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS 20 stylu " any squee Promisis C COMPLETION OF CAUSE 1 TYES 2 T NO DF DEATH? Directes 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: 1 TYES 2 LINE 1 Inpetient 2 ER/Outpetient 3 DOA 4 H Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify) 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be COMPLETED 4 Homicide determined IMPORTANT: If item 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

29c, LICENSE NUMBER

1131 Bel Air Road, Bel Air, MD., 21014

28136

29d. DATE SIGNED (Month, Day, Year)

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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June Trving Larry 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS HOURS 1 🔀 M 2 🗌 F VIDS 213-60-9079 13 Feb. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF CEATH 9e. FACILITY NAME (If not institution, give street end number) DIRECTOR 507 Saunders Avenue Cambridge 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10e. STATE Maryland Dorchester Cambridge permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE burial-transit 507 Saunders Avenue 21613 urs after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 27 NO 13 WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS If yes, specify Cuban, Mexican, Puarto Rican, etc.) FORCES? 1 \( \text{YES} 2\)
IF YES, GIVE WAR OR DATES 1 Nover Married 2 Married 1 TYES 27 NO Specify BY 3 Widowed 4 Divorced funeral director, page 5 should be detached for use as the COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 15. DECEDENT'S EDUCATION pecify only highest grade complet (Sne College (1-4 or 5+) Elementary/Secondary (0-12) 12 Carpenter Construction once. 18 MOTHER'S NAME (First Middle Melden Surname) 17. FATHER'S NAME (First, Middle, Last) 76 Norwood Wilson Marie Cooper BE notified 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 507 Cambridge Maryland21613 Marie Cooper Saunders Ave. must be 20e. METHOD OF DISPOSITION

132 Buriel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or Zion Church Cemetery Donetion 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Henry Funeral Home 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and sk, or heart fellure. List only one cause on each line. 510WashingtonSt Cambridge completely filled in by the medical 6 IMMEDIATE CAUSE (Finel the cremation, disease or condition resulting in death) event, OR AS A CONSEQUENCE OF executed this certificate has been signed by the attending physician and con-with the State Dept, of Health and Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING certificate be CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 death Injury, 24s. WAS AN AUTOR PART is other algorificant conditions contributing to death but not resulting in the underlying and given in Part I. the MEDICAL 10 any CA TYES I NO Shows 3 requires PHYSICIAN: Item 23 MP 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) The OTHER: 1 YES 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence S Other (Specify) ATTENDING PHYSICIAN: 4 - Nursing Home 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Mertiral 5 Pending Investigation 1 YES 2 NO L DIRECTOR: After the hours after death v BY 2 Accident 2Se. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide e Could not be COMPLETED 28 4 Homicide determined Hem OR 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) and manner as stated. (Check only one) FUNERAL I HOSPITAL IMPORTANT: IF 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) and menner as stated. BE THE Deep 28 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

95 18979

VEAR

1952 Maryland

Dorchester

10g. CITIZEN OF WHAT COUNTRY?

Specify

Church Creek Md

**Black** 

IICA

14. RACE — American Indian,
Black, White, etc.

96 COUNTY OF DEATH

1995

3. TIME OF DEATH

:15

10d. INSIDE CITY

1 🔀 YES 2 🗌 NO

Approximate interval Between Onset and Death

4/6

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 - YES 2 - NO

OF DEATH?

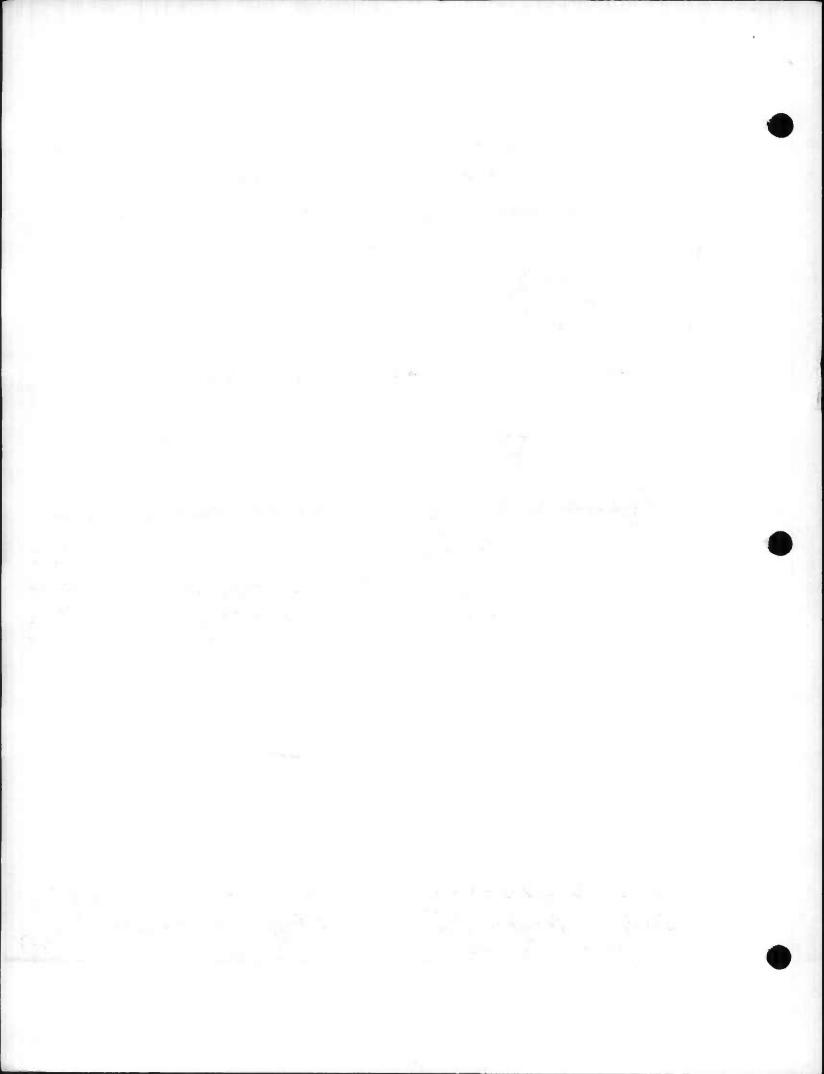
29d. DATE SIGNED Month, Day

8. BIRTNPLACE (State or Foreign

2. DATE OF DEATH MONTH

10

DHMH-18 Rev 1/89



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BALTIMORE	death. F	funeral
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DIVISION OF VILAL RECORDS, P.O. BOX 68760	R ATTEN	RECTOR:
	0	ā
	HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa

	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	LI-1			OF DEATH	REG. No.		3. TIME OF DEATH		
	Walter C	OOK Was	lter Clin	ton Cool	K	JUNE (	199	5 11:23 6		
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birtho	- //		7. DATE OF BIRTH (Month, Day, Year)	0.1	BIRTHPLACE (State or Foreign Country)		
	213-03-1400	1 📉 M 2 🗌 F	80 YR	S.	AYS HOURS MIN.	Oct.11,	1914	Maryland		
~	9e. FACILITY NAME (If not institution, give	street and number)		96. CITY, TO	WN OR LOCATION OF D	DEATH	Bc. COUNTY	OF DEATH		
5	NOTTH AND	del Hosp	ital	616	on Burn	10	Anne	· Arunde/		
DIRECTOR	10a. STATE 10b. COUNT	TY	10c.	CITY, TOWN OR L	OCATION			10d. INSIDE CITY		
	Maryland An	ne Arundel		Crow	nsville			LIMITS?		
AL	10a. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	845 Valentine V	iew			2103	2	U.S	S.A.		
Ę	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARA  1 Never Married 2 Married FORCES? 1 YES 2 No.			13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Y		RACE — American Indian, Black, White, alc.		
ВУ	1 Never Married 2 Married FORCES? 1 YES 2 AII 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES				s, specify Cuban, Mexic YES 2 NO Speci			Specify:		
0	15. DECEDENT'S ED	ICATION	Tee Proper	1				White		
ETE	(Specify only highest grad	le completed)	(Give kind	IT'S USUAL OCCU I of work done durin Of use retired.)	PATION og most of working	16b. KIND OF B	JSINESS/INDUST	RY		
PLI	Elementary/Secondary (0-12) Coffege (1-4 or 5+)			rew chi	ef	ai	rport			
COMPL	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maide	•			
ш	Ernest Hamond			The second secon	Sophia Ti					
0 8	19a. INFORMANT'S NAME (Type/Print)		ING ADDRESS (SI		Route Number, City or To		(e)			
2	Ronald G. Cook		845	Valent:	ine View	Crownsvi	lle, MI	21032		
	20a, METHOD OF DISPOSITION 1 [A Burlai 2 Cremation 3 Ren	noval from State	20b. PLACE AND DA	TEOFDISPOSITIO	N (Name of	OATE 20c. L	DCATION - City	or Town, State		
	4 Donation 5 Other (Specify)		Sams Cr	eek Cem	etery	6/13 nr.	New Wi	ndsor, MD		
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE /	1.	22. NAN	E AND ACCRESS OF FA	D.D. Ha	rtzlar	& Sons		
	New Windsor, MD									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
	IMMEDIATE CAUSE (Final							Interval Betwo		
	disease or condition reaulting in death)	gertive	Leent	La lan	2		3:.~			
		DUE TO (OR	AS A CONSEQUENC	E OF):	0			5.0		
2	Sequentially list conditions,	a. Con DUE TO (OR DUE TO (OR	in any	artin	1 direce	re		year		
	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR	AS A CONSEQUENCE	E OF):						
3	CAUSE (Disease or injury	c	AS A CONSEQUENCE	E OF						
ERTIFICATION	that initiated eventa resulting in death) LAST		AN A GONGLOGING	2 0. 7.						
S	d									
¥	PART II. Other algnificent condition	. A		ng in the under	lying cause given in	Part I. 24s, WAS A		24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO		
EDICA	- Chronic o	betweetin	- pul	monon	y direase	1 TYES	2 (NO	OF DEATH?		
≥	DID TODA COO HOT COA						× 1	1 TYES 2 NO		
Ä	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUS				N 🗆				
SICIAN:	EXAMINER?	HOSPITAL:		OTHER:						
PHYS	27. MANNER OF DEATH	1 Inpetient 2 ER			Home 5 Residence		IN HIER COOK			
	1 Netural 5 Pending	(Month, Day, Y		INJURY	WORK?	28d. DESCRIBE HOW	INJUNY OCCURE	U		
ă e	2 Accident investigation 3 Suicide 8 Could not be	m, street, factory,		28f. LOCATION (Street	and Number or D	and South Number				
	4 Homicide 8 Could not be determined	building, atc.	(Specify)	,		City or Town, State	)	are riotal riotation,		
	29a. CERTIFIER 1 DEFRIEVING PHYS	ICIAN: To the heat of	knowledge doub	numeral and the state	an in a later of the		20/10/10/20			
LETED	(Check only	ICIAN: To the best of my						world and		
MPLETE		ER: On the basis of exami	nation ang/or investo			r rivire, Gere SOG BISCS, S	THE CILIE TO THE CAN			
COMPLETE	2 MEDICAL EXAMIN		nation and/or investig							
			nation and/or investig		29c. LICENSE NUI			NEO (Month, Day, Year)		

31. DATE FILED (MODIF TON MA) 32. REGISTRAR'S SIGNATURE

July Division Author

retained by the hospital or attending physician.

Page 6 may be

hours after death.

the death certificate be executed within

DIVISION OF VITAL RECORDS, P.O. BOX 68760

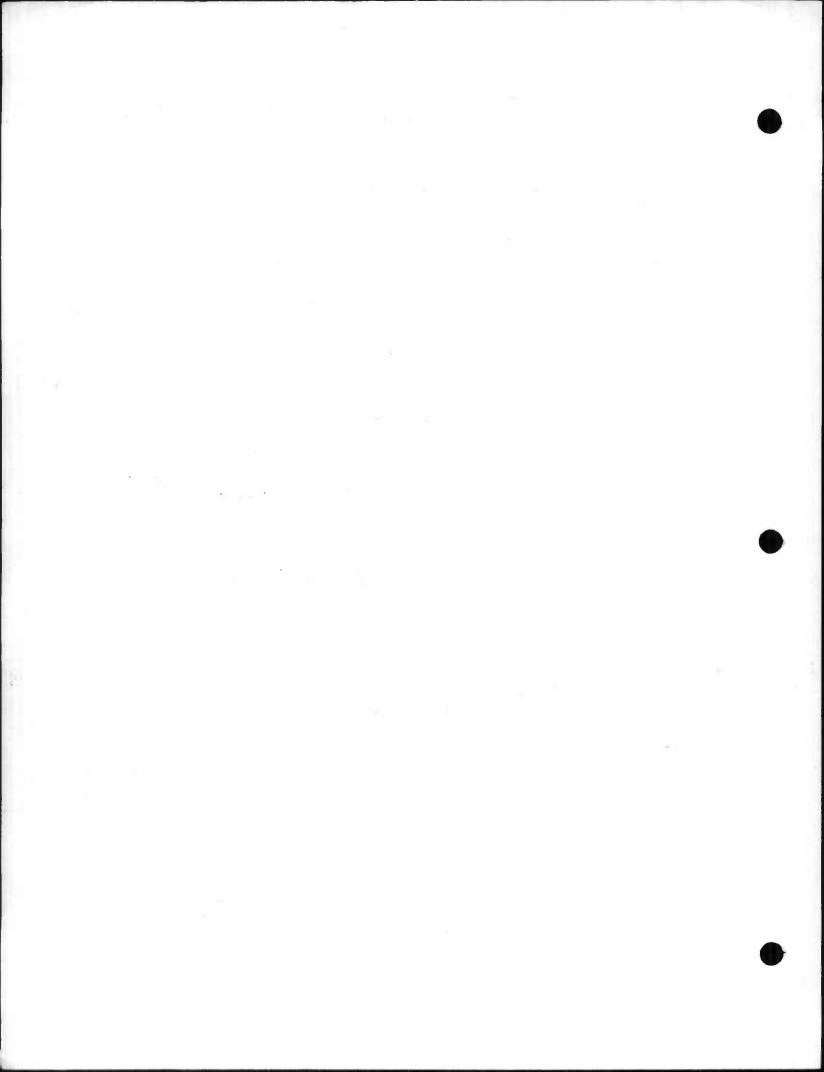
requires that

He H

BALTIMORE, MARYLAND 21215-0020

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 24PAY 1995 DAVID MAY 2035 P WILLIAM CLENNEY 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Yea 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 ( M 2 | F 219-46-5708 July 24, 1947 Washington, DC Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Hyattsville 1 YES 2 X NO permit. FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? use as the burial-transit 4801 Decatur Street 20781 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 X Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) BY 1 TES 2 NO Specify Specify: 3 Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only h detached for Elementary/Secondary (0-12) College (1-4 or 5 +) 10 Self-Employed Sales 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Sumarne) n and completely filled in by the funeral director, page 5 should be to burial, cremation, or removal. Ħ Cleveland Clenney Elderjean Martin BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Loretta Clenney 4801 Decatur Street, Hyattsville, MD 20781 þ 20e. METHOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State
4 Denetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Fort Lincoln Cemetery 5/30/95 Brentwood, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. Maro 3401 Bladensburg Rd., Brentwood, MD 20722 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, Approximate shock, or heert feilurs. List only one ceuse on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disesse or condition NARCOTIC & ALCOHOL INTOXICATION event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disesse Dr injury other that initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL signed by t any COMPLETION OF CAUSE 1XXES 2 NO 1 YES 2 NO has been Dept. of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \square\) UNCERTAIN \( \square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tem certificate h L OR ATTENDING PHYSICIAN: Th L DIRECTOR; After this certificate i hours after death with the State HOSPITAL: OTHER: XXVES 2 NO 1 | Inpetient 2X XR/Outpetient 3 | DOA Nursing Home 5 Rasidence 6 Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY with t 28d. DESCRIBE HOW INJURY OCCURED marked, 28b. TIME OF 26c. INJURY AT WORK? 1 Netural 5 Pending Investigati 5/24/95 PM 7:50 1 YES 2 XX NO BY 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) PRINCE GEORE 28t. LOCATION (Street and Number or Rural Route Number, 12 City or Town, State) 40 3 Sulcide 6 (XXCould not be COMPLETED 4 Homicide 4801 DECATUR ST. EDMONSTON, MD. CO. 29a. CERTIFIER 1 \_ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. HOSPITAL ( FUNERAL D within 72 h 2 MEDICAL EXAMINER: On the besis of axe TO THE HOSPITA
TO THE FUNERA
De filed within 7.
IMPORTANT: 1 nation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIONED (Month, Day, Year) O.C.M.E MAY 25,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M Woral 11 PENN STREET Exular BALTIMORE, MARYLAND 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

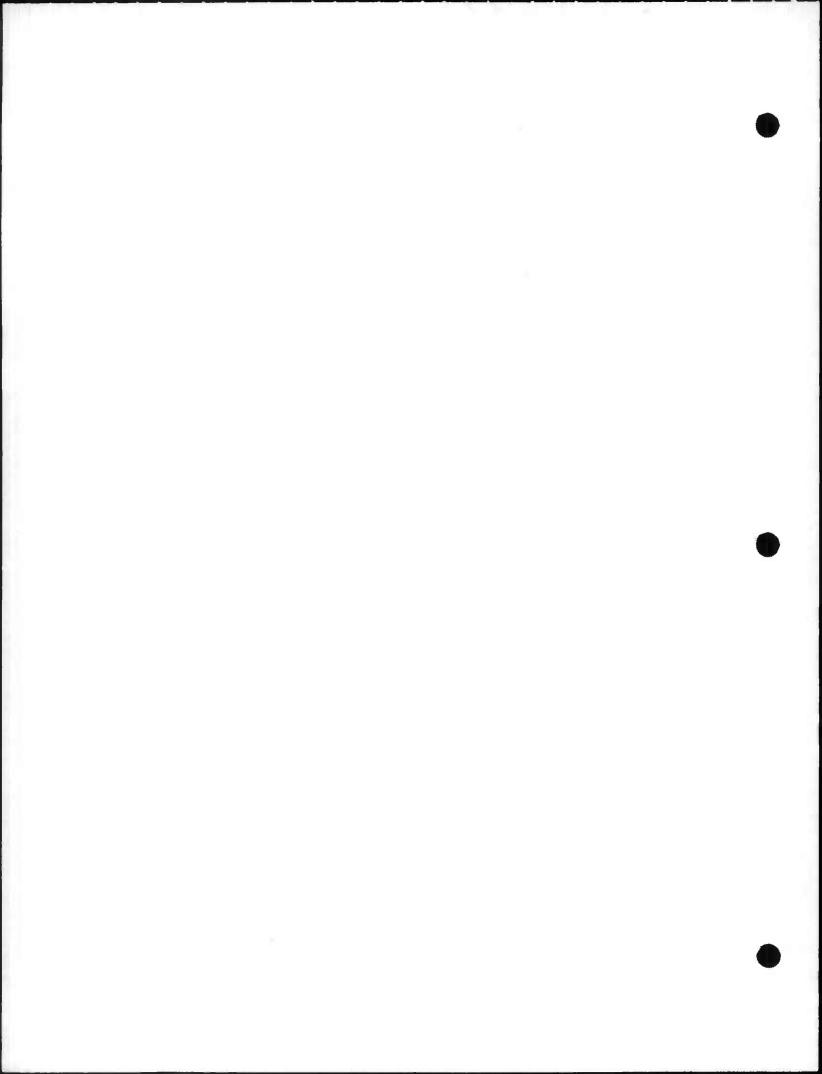
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE PLANETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be need within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IN THE PLANETAL III have 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	RTIFIC	ATE OF	DEATH	1	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF				3. TIME OF DE	EATH
	AUBREY	S. C	ORPR	EW			June	1		YEAR	1:10	D M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. lest be		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF		199		IPLACE (State or	
	578-54-4572	1X M 2   F	99		THE DAYS	HOURS MIN.	(Month, D	ey. Year)	0 =	Count	ry)	r Greigi.
- 1	9a. FACILITY NAME (If not institution, give st	reet and number)		96	CITY TOWN	OR LOCATION OF D		7/10		MIX OF E	bama	
Œ	Greenbelt Nurs		- 0.30	-			CAIN					
6	RESIDENCE OF DECEDENT	riig Ceiri	-61		Gree	nbelt			Pri	nce	Georg	je's
<u></u>	10a. STATE 10b. COUNTY	,		10c. CITY, TO	WN OR LOCA	TION					10d. INSIDE C	TY
<b>%</b>	Md.	P. 6	3.	Car	oitol	Hqts.					LIMITS?	
7	10e. STREET AND NUMBER				10	. ZIP CODE		_	100 017	TEN OF	WHAT COUNTRY	
FUNERAL DIRECTOR	1500	Elkwood	Tn #	202		20743						7
Z	13 U 9	12. WAS DECEDENT								.S.		
	1 Never Married 2 Married	FORCES? 1	YES 2 NO	D		ENDENT OF HISPAI			or No-	14. RACI Blec	E — American In k, White, etc.	idian,
BY	5) Widowed 4 Divorced	IF YES, GIVE WA			1 TYES	2 NO Specif	<b>y</b> .			Spec		
	15. DECEDENT'S EDUC	WW			l						DIAC	. 1
	(Specify only highest grade	completed)	(Give	kind of work	AL OCCUPATION MO	on at of working	16b. KII	ND OF BUS	BINESS/IN	DUSTRY		
7	Elementary/Secondary (0-12)	Coffege (1-4 or 5 +)		ster			Pr	inti	na	Off:	ice	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	l yr.		3001	11011					OLL.	LCC	
8						18. MOTHER'S NA						
BE	Elbert Co	rprew					zzie					
2	19a. INFORMANT'S NAME (Type/Print)					nd Number or Rural						
	Julius Wilson		47	20 N	ash S	t.,Capi	Ltol I	Igts	. , Mc	1. 2	0743	
- 1	20a. METHOD OF DISPOSITION  1 XBurial 2 Cremation 3 Remo	oval from State	20b. PLACE AND	DATE OF DI	SPOSITION (Ne	me of	DATE	20c. LO	CATION —	City or To	own, Stata	
	4 Donation 6 Other (Specify)		Harmo	ony N	lem. I	Park 6/	7/95	Lar	ndov	er,1	Md.	
ij	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAME A	D ADDRESS OF FA	CILITY		'one	T		
- 22	1 X arry	el C.	att		49	ACCRESS OF FA Washi 25 Burr	oughs	Ανε	oons M	, THO	С.	
	23. PART I. Enter the diseases, or c											
	ahock, or heart fallure. I	List only one caus	e on each line.	n. Do not e	enter the mo	de or dying, auc	n as cerdiac	or respi	natory ar	rest,	Approxi	mata Between
	iMMEDIATE CAUSE (Finel disease or condition										Onset e	nd Death
	reaulting in death)	_Athero	sclerot	cic (	Cardio	vaascu	lar D	isea	ase			
1		DUE TO (C	OR AS A CONSEQUE	ENCE OF):								
Z	Sequentially list conditions,	λ										
Ĕ	if eny, leeding to immediate	DUE TO (C	OR AS A CONSEQUE	ENCE OF):								
5	CAUSE (Disease or injury											
ĔΙ	that initiated eventa resulting in death) LAST	DOE 10 (C	OR AS A CONSEQUE	ENCE OF):								
CERTIFICATION		1										
	PART ii. Other aignificent condition	e contributing to d	leeth but not rest	ulting in th	a underiving	ceuse given in	Part i. 24	n. WAS AN	AUTOPSY	24b	WERE AUTOPSY	FINDINGS
MEDICAL	Abdominal a							PERFOR	MED?	"	AVAILABLE PRIC	OT RO
	Chronic and	mis	neurysi				- 1	YES 2	₩ ио		OF DEATH?	CAUSE
	Chronic and						_				1 YES 2	NO NO
PHYSICIAN:	DID TOBACCO USE CONTR	GIBOTE TO CAU				UNCERTAIL	ИПП					
$\frac{1}{2}$	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE C		heck only one) HER:							
YSI	1 TYES 2 X NO	1 Inpatient 2 I	ER/Outpatient 3			e 5 🗆 Residence	6 Other (S)	pecify)				
표	27. MANNER OF OEATH	28a. OATE OF III (Month, Day	NJURY 2 Year)	8b. TIME OF	26c. INJ	URY AT	28d. OESCRI	BE HOW II	NJURY OC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation					ES 2 NO						
- 1	3 Suicide 8 Could not be	28a. PLACE OF building, at	INJURY — At home,	, farm, street	, factory, offic		26f. LOCATIO		nd Number	r or Rural F	Route Number,	
ш	4 Homicide datarmined		(0,00),				City or A	own, State)				
7 1	29a. CERTIFIER (Check only	CIAN: To the best of m	v knowledge, death	occurred at	the time date	and place, and due	to the coursele	a) and man		10.4		
COMPLETED	(Check only one) 2 MEDICAL EXAMINER										l) and masses	stated
	29b. SIGNATURE AND TITLE OF CERTIFIER				,			grace, dir				
H	WILL CONTINUE AND THE OF CENTIFIER	7.	an			29c. LICENSE NUI					(Month, Day, Yea	
<u>و</u> ا	14 Company	) ger,	1)			D39550	)		Jı	une	2,199	5
	30. NAME AND ADDRESS OF PERSON WHO							50				
	George C. Hajja			50 F	orbes	Blvd.	Lanha	am, M	d. 2	2071	6	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAN										
100		T. I STA . ALLA A	MAJ. II									

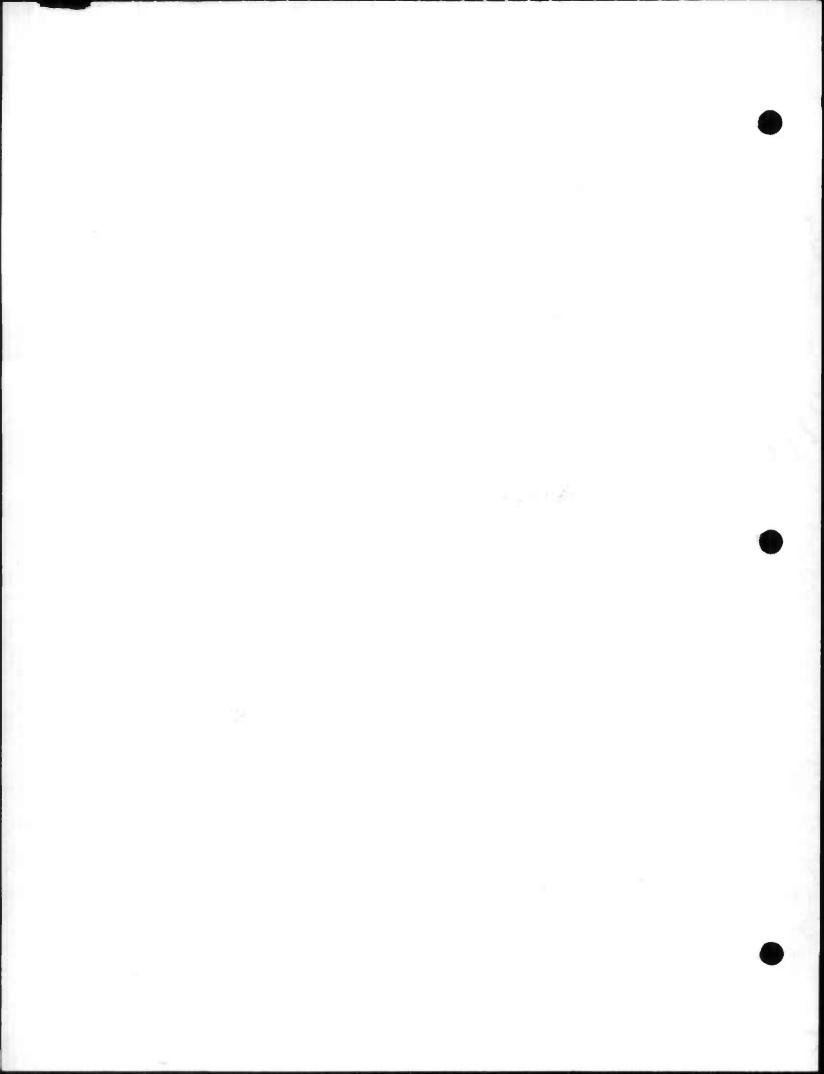


DIVISION OF VITAL RECORDS, P.O. BOX 68760

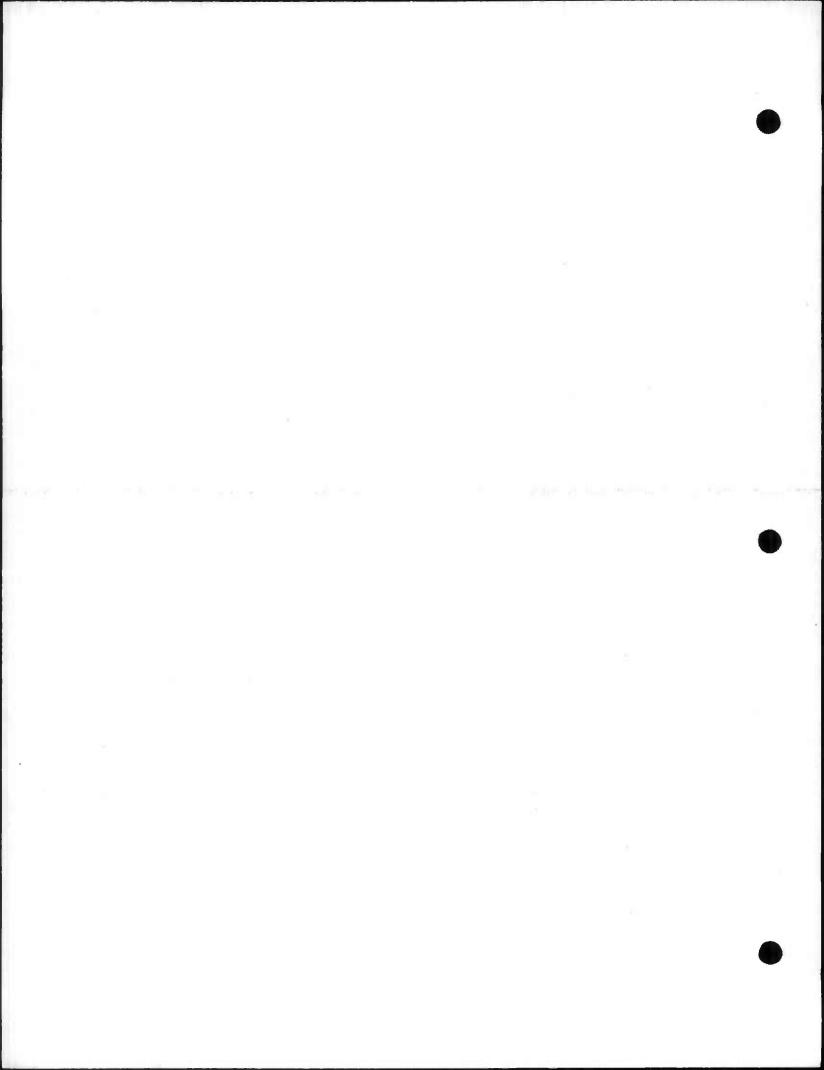
THE HUBBAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

										REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATN  3. TIME OF DEATN												3. TIME OF DEATN
	Henry Alexande	r Cu	umberla	ınd					May :	31. 1	995	YEAR	12:27 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1	1 YEAR	IF UNDER	24 HRS.					PLACE (State or Foreign
	578-12-2044	1 🔯 M 2 🗆 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)		Country)		V)
	9e. FACILITY NAME (If not institution, give	street and number)	- 01		9b. CITY, TOWN OR LOCATION OF DEA			Sept. 4, 1910				hington, DC	
Œ	6201 41st Avenue					_			AIN			NTY OF D	
6	RESIDENCE OF DECEDENT				нуа	itts	vill	e			Pri	nce (	George's
8	10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OF	R LOCAT	ION						10d. INSIDE CITY
DIRECTOR	Maryland Prince George's Hyattsville											- 1	LIMITS?
	10a. STREET AND NUMBER	o occipe		117 0	CCSVI		ZIP CODE						1 05 YES 2 NO
FUNERAL	6201 41st Avenue												HAT COUNTRY?
빌	11. MARITAL STATUS	ARMED			2078				U.S				
5	1 Never Married 2 X Married	13. W	WAS DEC	ENDENT C	F NISPAN	IC ORIGIN? (	Specify Yes	or No-	14. RACE Black	- American Indian, White, etc.			
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		t	☐ YES	2 📉 NO	Specify.		,	ı	Speci	
	15, DECEDENT'S EDU	ICATION .			1								
#	(Specify only highest grade			DECEDENT'S (Give kind of site. Do NOT us	work done du	uring mos	in st of workin	g	16b. Ki	NO OF BUS	INESS/IND	USTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5 +	)		•				177 /		1		
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)		DI	anch	Manag	er	_			. Po		Serv	/ice
		0 1 1	•						AE (First, Mide		Surname)		
BE	Henry Alexander	Cumberlan							th T.				
2	19a. INFORMANT'S NAME (Type/Print)	1		19b. MAILING									
- 1	Edith L. Cumberl	and		6201	41st	Ave	nue,	Hya	ttsvi	le,	Mary	Land	20782
. 0	20a. METHOD OF DISPOSITION	ioval from State	20b. PLAC	E AND DATE	OF DISPOSIT	TION (Na	me of		DATE	20c. LO	CATION —	City or To-	wn, State
	1N Buriel 2 Cremetton 3 Removal from State 4 Donation 6 Other (Specify) Gate of Heaven Cemetery 6/3/95 Silver Spring,										g, MD		
- 13	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. N	AME AN	D ADDRES	S OF FAC	WI IFV			_	
- 1	MARA												ne, P.A.
	23. PART i. Enter the diseases, or	complications that	coursed the	death De	4/	39	Balt:	imore	Ave.	, Ну	atts	Jille	e, MD 20781
	ahock, or heart fellure.	List only one caus	se on each ii	ne.	iot enter t	ine moi	se or ayı	ng, such	aa cerdiad	or reapi	ratory arr	eat,	Approximata interval Between
	IMMEDIATE CAUSE (Final									Onset and Death			
- 1	disease or condition resulting in death)	. ASCVD											l hr
			OR AS A CONS										
Z.	Sequentielly list conditions,	Carcino				Le							
Ĕ	if any, leeding to immediate	DUE TO (	OR AS A CONS	SEQUENCE OF	F):								
2	CAUSE (Disease or injury	c											
LL II	that initiated events	DUE TO (	OR AS A CONS	EQUENCE O	F):								
E 1	that initisted events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST												
ERTI	resulting in death) LAST	d											
- CERTII		d	death but no	t resulting	in the und	dominina		due to f	na i Ta			1	
CAL CERTI	PART II. Other aignificant condition	d	death but no	t reaulting	n the und	derlying	ceuse g	lven in f		a. WAS AN	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
DICAL CERTI		d	death but no	t resulting	n the und	derlying	ceuse g	plven in f			MED?	24b.	
MEDICAL CERTIFICATION	PART II. Other algorificant condition	d.						plven in f		PERFOR	MED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	PART II. Other aignificant condition	d.	JSE OF DE	ATH YE	s 🗆 N	10 🗆		ertain	_ 1	PERFOR	MED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
Σ	PART II. Other algorificant condition	d. ne contributing to d	JSE OF DE	ATH YE	S N	IO []			_ 1	PERFOR	MED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
Σ	PART II. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL	d.	JSE OF DE	ATH YE	S N (Check or OTHER:	IO []	UNC	ERTAIN	_ 1	PERFOR	MED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
Σ	DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 XYES 2 NO  27. MANNER OF DEATN	RIBUTE TO CAL  HOSPITAL: 1   Inpetient 2 X	JSE OF DE 28. PL ER/Outpetient	ATH YE	S N N (Check of OTHER:	IO []	UNC	ERTAIN	1	PERFOR	MED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
PHYSICIAN: M	DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATN  1 X Netural S Pending	RIBUTE TO CAL	JSE OF DE 28. PL ER/Outpetient	ATH YE	S N (Check or OTHER:	IO [] nily one) : ng Nome 28c. INJL	UNC	ERTAIN	1 Other (S	PERFOR	MED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
BY PHYSICIAN: M	PART II. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation	RIBUTE TO CAL  HOSPITAL: 1 Inpatient 2 X  28a. DATE OF I	JSE OF DE  28. PL  ER/Outpetlent INJURY  V, Yber)  INJURY — At	ATH YEAGE OF DEAL	N (Check or OTHER:	IO III	UNC  5 G Re  JRY AT  RK?  ES 2 [	ERTAIN	Other (S 28d. DESCR	PERFOR	MED?	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  † YES 2 NO
BY PHYSICIAN: M	DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATN  1 X Netural 5 Pending Investigation	RIBUTE TO CAL  HOSPITAL: 1 Inpatient 2 X  28a. DATE OF I	JSE OF DE 28. PL ER/Outpatient INJURY y, Year)	ATH YEAGE OF DEAL	N (Check or OTHER:	IO III	UNC  5 G Re  JRY AT  RK?  ES 2 [	ERTAIN	Other (S 28d. DESCR	PERFOR	MED?	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  † YES 2 NO
BY PHYSICIAN: M	PART II. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Netural 5 Pending Investigation  3  Suicide 6 Could not be detarmined	RIBUTE TO CAL  HOSPITAL: 1 Inpatient 2 X  28a. DATE OF i (Month, De	JSE OF DE  28. PL  ER/Outpatient INJURY   , 'Vea')  INJURY — At the (Specify)	ATH YEACE OF DEAT	SS N N (Check or OTHER: 4 Number of the State of URY M street, factor	IO	UNC  5 Re  PRY AT  RK?  ES 2	ERTAIN sidence (	Other (S 28d. DESCR 28t. LOCATIO	PERFOR YES 2	NO NO NO NO NO NO NO NO NO NO NO NO NO N	CURED or Rural A	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  † YES 2 NO
BY PHYSICIAN: M	PART N. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only)	RIBUTE TO CAL  HOSPITAL: 1   Inpetient 2 Al  28a. DATE OF I (Month, De	JSE OF DE  28. PL  ER/Outpatient INJURY y, 'bar)  INJURY — At atc. (Specify)  my knowledge,	ATH YE ACE OF DEAT 3 DOA 26b. TIM INJ home, term, s	SS N N (Check or OTHER: 4 Nursil E OF URY M	inly one): ing Nome 28c. INJL WOF 1 Y ry, office	UNC  5 Re  JRY AT  RK7 ES 2	ERTAIN sidence (	3 Other (S 28d, DESCR City or 1	PERFOR  YES 2  Decily)  BE NOW IN  ON (Street a own, State)	MED? NO  NO  NO  NO  NO  NO  NO  NO  NO  NO	OURED or Rural A	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  t YES 2 NO
BY PHYSICIAN: M	PART II. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only One)  2 X MEDICAL EXAMINE	RIBUTE TO CAL  HOSPITAL: 1 Inpetient 2 Al  28e. PLACE OF building, a	JSE OF DE  28. PL  ER/Outpatient INJURY y, 'bar)  INJURY — At atc. (Specify)  my knowledge,	ATH YE ACE OF DEAT 3 DOA 26b. TIM INJ home, term, s	SS N N (Check or OTHER: 4 Nursil E OF URY M	inly one): ing Nome 28c. INJL WOF 1 Y ry, office	UNC  5 Re  JRY AT  RK7 ES 2	ERTAIN sidence (	3 Other (S 28d, DESCR City or 1	PERFOR  YES 2  Decily)  BE NOW IN  ON (Street a own, State)	MED? NO  NO  NO  NO  NO  NO  NO  NO  NO  NO	OURED or Rural A	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  t YES 2 NO
COMPLETED BY PHYSICIAN: M	PART N. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only)	RIBUTE TO CAL  HOSPITAL: 1 Inpetient 2 Al  28e. PLACE OF building, a	JSE OF DE  28. PL  ER/Outpetfent INJURY — At itc. (Specify) my knowledge, amination and/o	ATH YE ACE OF DEAT 3 DOA 28b. TIM home, tarm, s death occurr or Investigation	SS N N (Check or OTHER: 4 Nursil E OF URY M	inly one): ing Nome 28c. INJL WOF 1 Y ry, office	UNC  5 Re JRY AT RK7 ES 2   and place, with occurrent	ERTAIN sidence (	Other (S 28d. DESCR 28t. LOCATION of 1 to the cause)	PERFOR  YES 2  Decily)  BE NOW IN  ON (Street a own, State)	MED?  NO  NJURY OCC  Ind Number  ner as state d due to the	or Rurel R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  t YES 2 NO  oute Number,  and manner as stated.
BE COMPLETED BY PHYSICIAN: M	PART II. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X YES 2 NO  27. MANNER OF DEATN  1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only one)  2 X MEDICAL EXAMINE  29b. SIGNATURE AND TITLE OF CERTIFIE	RIBUTE TO CAL  HOSPITAL: 1 Inpatient 2 & 28a. DATE OF building, a	JSE OF DE  28. PL  ER/Outpatient NJURY y, 'ber')  FINJURY — At titc. (Specify)  my knowledge, amination and/o	ATH YE ACE OF DEAT  3 DOA  26b. TIM INJ  home, tarm, s  death occurr or investigation	S N (Check or OTHER: 4 Number of Num	inly one): ing Nome 28c. INJL WOF 1 Y ry, office	UNC  5 Re JRY AT RK7 ES 2   and place, with occurrent	ERTAIN sidence (	Other (S 28d. DESCR 28t. LOCATION of 1 to the cause)	PERFOR  YES 2  Decily)  BE NOW IN  ON (Street a own, State)	MED?  NO  NJURY OCC  Ind Number  ner as state d due to the	or Rurel R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  t YES 2 NO  oute Number,  and manner as stated.
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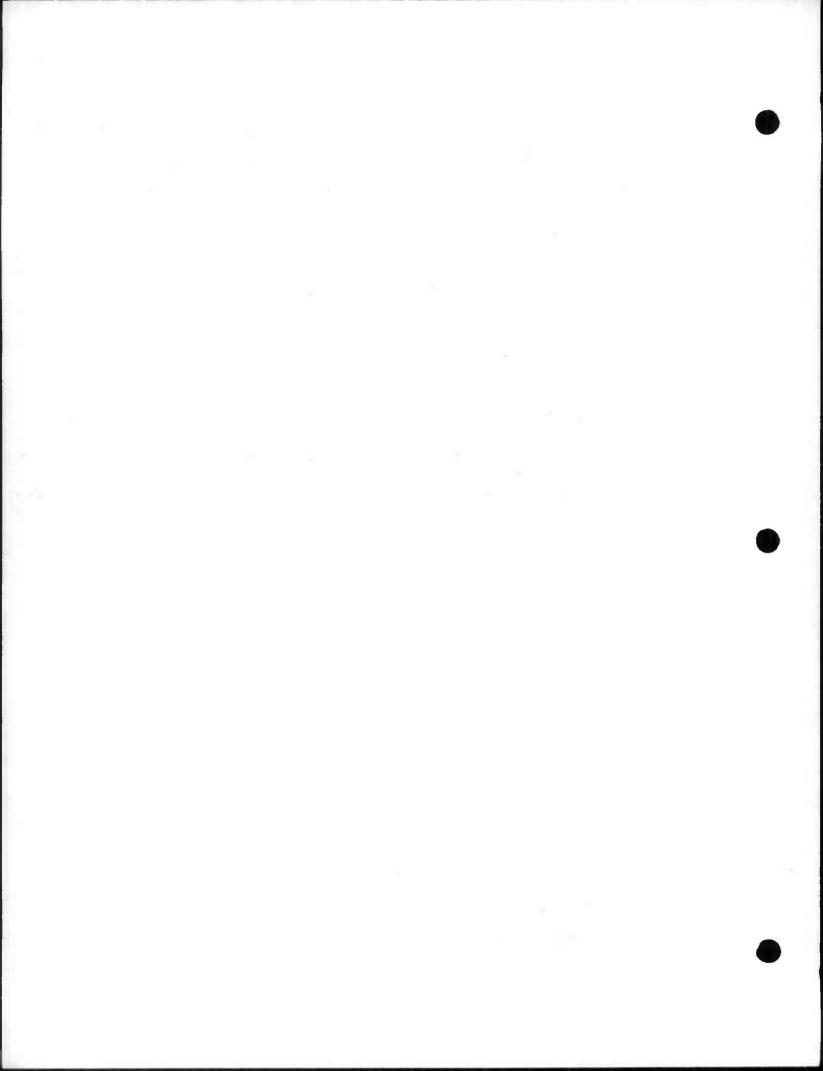
		1 - FOR STATE REGISTRAR	OF MARYLAN	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last)	2				2. DATE OF DEATH		EAR	TIME OF DEATH
		Cicero A.  4. SOCIAL SECURITY NUMBER 5. SEX					June 7 1			6:30pm M
Pla		218-18-7837 1 🖾 M 2	□	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb 14 1	904 V	irgi	
2, 3 should	DIRECTOR	431 Telegraph Rd	noer)		Rising	or location of d	EATH	ec. COUNTY	of DEATH	
	EC	RESIDENCE OF DECEDENT  10e. BTATE 10e. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d	. INSIDE CITY
permit. Pages		MD Cecil		Ri	sing Sur				1 [	LIMITS?  YES 2 NO
	RAL	431 Telegraph Rd			10	1. ZIP CODE 21911		USA	OF WHAT	COUNTRY?
1215-0020 or attending physician. r use as the burial-transit	BY FUNER	11. MARITAL STATUS 12. WAS D	DECEDENT EVER IN U ES? 1 TYES I, GIVE WAR OR DATE	2 NO	If yes, so	CENDENT OF HISPA	NIC ORIGIN? (Specify Youn, Puerto Rican, etc.)	es or No— 14.	Black, Wit Specify:	American Indian, lite, etc.
ttendii	ETED	15. DECEDENT'S EDUCATION	90	6a. DECEDENT'S	USUAL OCCUPATI	ON	16b, KIND OF BU	W1	nite	
O 212 pital or a	PLET	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4 or 5+)	(Give kind of ville. Do NOT us		ost of working		vernmen		
YLAND 2. by the hospital of the detached for at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		marine	liance	16. MOTHER'S NA	AME (First, Middle, Maide		L	
YL de de de de de de de de de de de de de	BE C	Cortley W. Carter				100	Parks			
MAR e retained e 5 should notified	TO E	190. INFORMANT'S NAME (Type/Print) Thelma M. Carter					Route Number, City or To			
RE, may be c page		20a. METHOD OF DISPOSITION 1 Disposition 3 Removal from 5	20b. PI	LACE AND DATE	DEDISPOSITION /N	ame of	DATE 20c II	OCATION — City		State
MOR age 6 may director, p		4 Donation 6 Other (Specify)	Wes	t Notti			10 1995	Colora	a MD	
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funeral director, page 5 should be detached for use as the burial moral.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	el.		R. T.		uneralHome St Rising	-	219	1.1
B, hours after d in by the or removal medical		23. PART I. Enter the diseesea, or complication ahock, or heart failure. List only of	one that caused the	he deeth. Do r	ot enter the mo	ode of dying, aud	th an cerdiac or reap	piratory arrest	,	Approximata Interval Between
Pe on file		IMMEDIATE CAUSE (Final								Onset and Death
3760 rted within 24 completely fille ial, cremation, event, the	1	resulting in death) a	DUE TO (OR AS A CO	ONSEQUENCE OF	a.					244.
cecuted with and complete to burial, crem	z		ASUD.		,					
BOX 68760 cate be executed with hysician and complet e prior to burial, cre- er traumatic even	VT10	If any, leading to immediate	DUE TO (OR AS A CO							
BC ficate physic ne pric	FICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events	TX OF A	ONSEQUENCE OF	n:					25 deg
RECORDS, P.O. BOX requires that the death certificate be reen signed by the attending physician or Health and Mental Hygiene prior to theatth and Mental Hygiene prior to shows any Injury, or other traur	CERTIFICATION	resulting in death) LAST	,		,				į	
DS, P the death the atter d Mental		PART II. Other algolificant conditions contribu	iting to death but	not resulting i	n the underlyin	a cause alven in	Part I. 24a, WAS A	M ALEMANAN	0.45 1455	RE AUTOPSY FINDINGS
ORC that the od by the	ICAL		and to doon but	not remarking t	in the underlyin	A caree diveil iii	PERFO	RMED?	AWA	LABLE PRIOR TO IPLETION OF CAUSE
aw requires that been signed by pt. of Health and 3 shows any	MEDIC						1 _ YES	2) (40		DEATH?
. 3 - 5 -		DID TOBACCO USE CONTRIBUTE 1	O CAUSE OF	DEATH YE	S NO E	UNCERTAIL	N 🗆			,
OF VITAL PHYSICIAN: The law this certificate has with the State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPIT		PLACE OF DEAT	H (Check only one) OTHER:					
. 5 5 5 9	PHYS	27. MANNER OF DEATH 26e.	ent 2 ER/Outpation	ent 3 DOA	4 - Nursing Hon	Nesidence	6 Other (Specify) 28d, DESCRIBE HOW	IN KIEW OCCUR	ED.	
ION OF NDING PHYSIC The this ce the death with the second of the second	ВУ Р	1 Natural 5 Pending 2 Accident investigation	Month, Day, Year)	INJ	M 1	YES 2 NO				
	TED	3 Suicide 6 Could not be 4 Homicide datermined	PLACE OF INJURY — pullding, etc. (Specify)	At home, lerm, s	itreet, lectory, offic	:•	26t. LOCATION (Street City or Town, State	t end Number or F e)	Rural Floute	Number,
로 로 로 보	COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the one) 2 MEDICAL EXAMINER: On the balance							ruse(e) end	manner es stated.
TO THE HOSPI TO THE FUNE TO THE FUNE TO THE MITHIN	ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE SI		
5 5 3 M	TO B	Jui this free MD  30. NAME AND ADDRESS OF PERSON WHO COMPLET	ED CAUSE OF DEATH	1 (ITEM 27) (Type	Print	D0482.	3	▶ 6/	8/45	
		THE CAN HELL A	1 22 2	11.1.00	mai !	ct, E	Flicton L	10 21	921	
		31. DATE FILED (Month, Dey. Year)  32. RI	EGISTRAR'S SIGNATI	all.						
		JUIT								DHMH.16 Rev 1/89



Amended #9a-c, 6/4/95, L.H., Frederick CO.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIFIC	ATE OF	DEATH		REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	nald Cai	n			2. DATE (	OF DEATH	N Y	S. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN.	7. DATE ( (Month,	Day, Year)	952	BIRTHPLACE (State or Foreign Country)
should		Se. FACILITY NAME (If not institution, give s	street and number)   8   65	metz Dr. 91	b. CITY, TOWN	OR LOCATION OF D		wary.	96. COUNTY	West Virginia
1, 2, 3 s	DIRECTOR	ABIJ RECEIPT	Mill Rd.		Fred	crick	Gern	rantown	7	Ederick
Pages	IRE(	10a. STATE 10b. COUNT	1		OWN OR LOCA	. /				10d. INSIDE CITY LIMITS?
permit. F		Maryland fr	ederick	Tre	deric	, ZIP CODE				1 TYES 2 NO
is.	FUNERAL	4813 Reels	Mill Roas	1		2170	1		Unix	hed States
DUZU g physician. e burial-transit		11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER III FORCES? 1 YES	2 NO	if yes, sp	ENDENT OF HISPA	an, Puerto R	(Specify Yealcan, etc.)	or No— 14.	RACE — American Indian, Black, White, etc.
attending p	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 PYES	2 NO Speci	ly.			sportich te
	TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of work life. Do NOT use re	t done during me	ON est of working	16b.	KIND OF BUS	SINESS/INDUS	TRY
the hospital or detached for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Printe				U.S.	60	v'+
The hospit detached once.	ON I	17. FATHER'S NAME (First, Middle, Last)		7. 1.0 ) [		18. MOTHER'S NA	ME (First, M			
# 8 & E	BE (	George D. (	ain			Ina	Bel	110	Cara	
retained 5 should notified	2	19a. INFORMANT'S NAME (Type/Print)	n -	196. MAILING AD	DRESS (Street a	and Number or Rurel	2	,	1, State, Zip Co	10(e)
page page		29s. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Benefit	ain 20t	PLACE AND DATE OF D	DISPOSITION (Ne		PAGE		CATION - CH	20706
mector.		1 Donation 8 Other (Specific	Swell from State	natery cramatory or other	place) enek		6/13	Bre	etuvo	d. Markage
DALLIMOT ber death. Page 6 m the funeral director. wal. si examiner must	1	21. SIGNATURE OF FUNERAL SERVICE LI	MENSEE		22. NAME AL	Truer	cility #	wos 1	2A.	1 7
after death.  y the funer.  moval.	- 0	- Tuan U	Drge	_	16210	occinton	In Per	6 h	Spring	E.HD 21702
in by reme		23. PART i. Enter the diseases, or ahock, or heart feliure.	complications that cause List only one cause or e	the deeth. Do not ach line.	enter the mo	de of dying, suc	h sa cardi	ec or respi	ratory arrest	t, Approximata interval Between
1 o 1		iMMEDIATE CAUSE (Final disease or condition	1							Onset and Death
within pletel crema		resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	nier					month)
and con burial.	Z	Sequentially list conditions,	b							
4 8 0 5	CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						
e by		CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):						
of H	ERTIF	resulting in death) LAST	d							
S S S S	N C	PART ii. Other significent condition	s contributing to deeth b	ut not resulting in t	he underlying	g cause given in	Part i.	24a, WAS AN		24b. WERE AUTOPSY FINDINGS
and the	EDICAL						_	PERFOR	1.0	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
· F OI P	Ξ	DID 700 100 100 100 100 100 100 100 100 100							1-	1 TES 2 NO
1 ye x 9 %	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		PEATH YES 26. PLACE OF DEATH (		UNCERTAI	И		54	
SiCLAN: The certificate h the State (	SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	0	THER:	e 5 KResidence	6 🗆 Other	(Passibil		
PHYSICIA this certii with the	РНУ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b, TIME O	F 28c. tNJ				NJURY OCCUR	RED
DING PHYS After this death with	BY	Netural 5 Pending Investigation			M 1 1	rES 2 NO				
TTEN TOR:		3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm, stree city)	et, tectory, offic		28f. LOCA City o	TION (Street a r Town, State)	nd Number or I	Rural Route Number,
Plour John	PLET	29a. CERTIFIER Check only	CIAN: To the beat of my know	ledge, death occurred a	t the time, date	and place, and due	to the caus	e(a) and men	ner se stated.	
HOSPITAL FUNERAL WITHIN 72	COMPL		R: On the basis of examination							ause(a) and manner as stated.
TO THE HOSPI TO THE FUNER De filed within	BE 0	296. SIGNATURE AND TITLE OF CERTIFIE	0	MN		29c. LICENSE NUI		_	29d. DATE SI	IGNED (Month, Day, Year)
5 5 3 W	5	30. NAME AND ADDRESS OF PERSON VI	O COMPLETED CAUSE OF DE	ATM OTEM OF CO.	ad)	D 32	635		-T-	2,12,1995
		JOSEBH KYDIO	m, 18111 by:	-a Philip	Dr.	ocasy.	MAR	Such	208	32
		31. DATE FILED (Month, Day, Year)  JUN 1 4 1995	32. REGISTRANS SIGN					¥		
	الـــــــــــــــــــــــــــــــــــــ									



FOR STATE REGISTRAR

t. DECEDENT'S NAME (First, A

4. SOCIAL SECURITY NUMBER

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7. DATE OF BIRTH (Month, Day, Year) April 20 1917 214-07-9720 DAYS 1 M 2 K F 78 YRS. should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Carroll County General Hospital Pages 1, 2, 3 Westminster RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION Maryland Carroll Westminster permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 201 St. Mark Way completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 21157 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) FORCES? t YES 2 2 X NO t Never Married 2 Married BY 1 YES 2 X NO Specify 3℃ Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) quality control electronics manufacturing 17. FATHER'S NAME (First, Middle, Lest) ts. MOTHER'S NAME (First, Middle, Maiden Surname) Walter Hurley Mary Ellen Gatton notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Sylvia Kunert 526 Ann Drive, Westminster MD 21157 Pe 20e. METHOD OF DISPOSITION
1XXBuriel 2 Cremetton 3 Rer
4 Donetion 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Dorchester Memorial Park 6/17 Cambridge Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY hours after death. Thomas Funeral Home 700 Locust St. Cambridge MD 21613 KKK Juan medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert fallura. List only one cause on sech line. 6 **IMMEDIATE CAUSE (Fins)** other traumatic event, the disesse or condition DIDI 8 executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF) and com CERTIFICATION Sequentially ilst conditions, QUE TO (OR AS A CONSEQUENCE OF): prior to if sny, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to requires that the death certificate CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 10 PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY AR any 1 - YES 2 100 n the State Dept. of 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Z PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The ltem! HOSPITAL: OTHER 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF OEATH 28a. DATE OF INJURY with t 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 \ \accident ATTENDING 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 28 9 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h Ξ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE. 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) Talia Davilson Rawfull 9 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

6. AGE (In yrs. last birthday)

2. DATE OF DEATH

3. TIME OF DEATH 10

10d. INSIDE CITY

1XXYES 2 NO

Approximats interval Batween

Onset and Death

4 years

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

t YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

8. BIRTHPLACE (State or Foreign

Maryland

tog. CITIZEN OF WHAT COUNTRY?

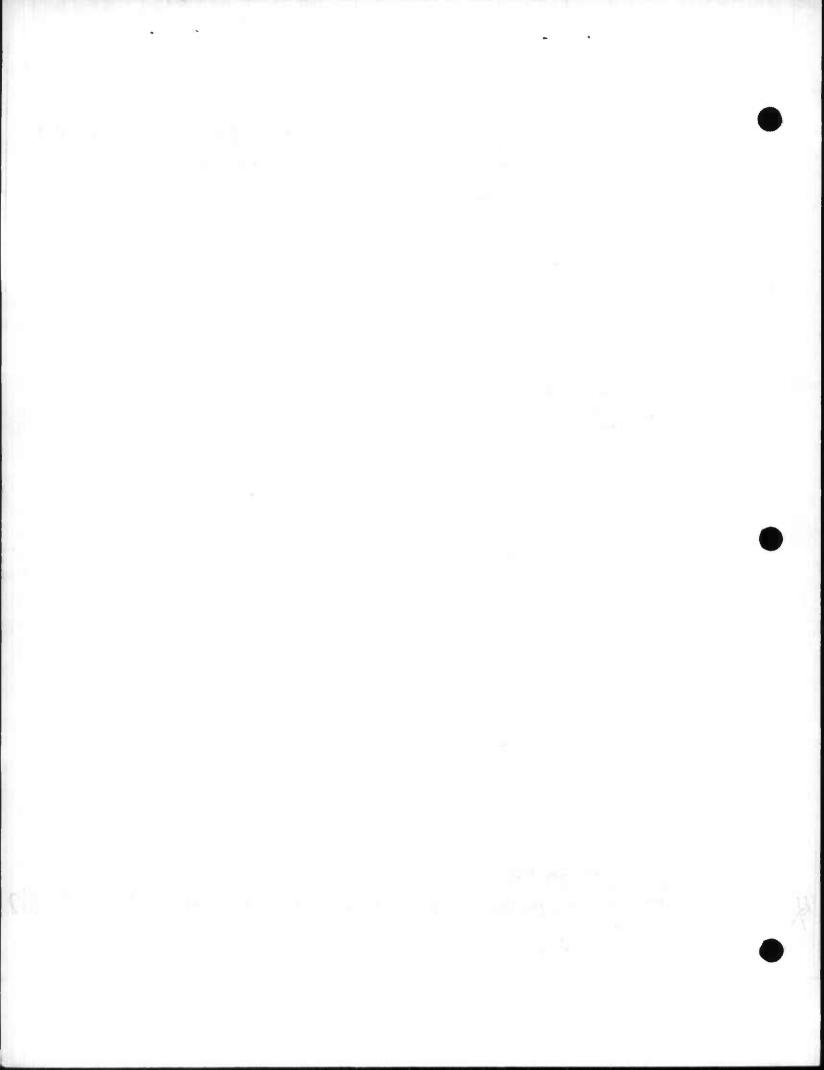
U.S.A.

14. RACE — American Indian, Black, White, etc.

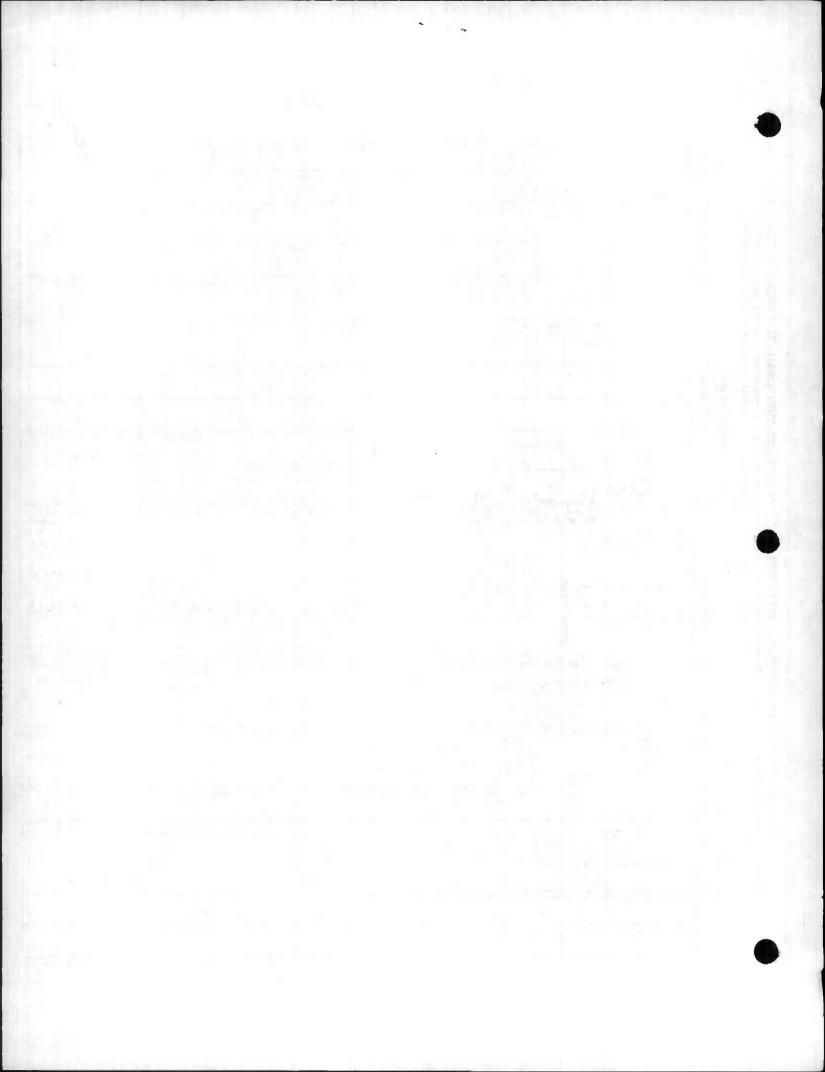
Specify: white

9c. COUNTY OF DEATH

Carroll



1. DEC					_,,,,,,,	ICATE			716	G. NO.		
	edent's name (First, Ella		Fr	ieda		Ca	sel	la	2. DATE OF D MONTH June		1995	9:00 p
	45-10-336		5. SEX	6. AGE (In yrs. I	est birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI	PTN 1911	a. BIRTNPI Country) Ger	ACE (State or Foreign
Ma Ma	nor Care	Nursi						Spring	DEATH		Montgo	TH
II 10e. 31	ATE Lryland	10b. COUNTY	_			y, TOWN O		ION				0d. INSIDE CITY LIMITS?  YES 2440
10e. S1	REET AND NUMBER	an Dri	VA				101	. ZIP CODE 20759		10g. (	U.S.A	AT COUNTRY?
· II 'L'	RITAL STATUS ever Married 2  Vidowed 4 Divo	Married	12. WAS DECEDEN	NT EVER IN U.S. A I YES 2 T	RMED NO	- 11	yea, spe	ENGENT OF NISPA	an, Puerto Rican,		- 14, RACE	- American Indian, White, etc.
ETED	(Specify only mentary/Secondary (0	EDENT'S EDU- highest grade		+)	DECEDENT'S 'Give kind of the Do NOT up	work done d se retired.)	CUPATIO	ON st of working	195100	OF BUSINESS/		
¥ 17. FAT	ade 6	iddle, Lest)		S	eamst	ress			AME (First, Middle	Lothing  Melden Surname		rry
19a. IN	IKNOWN FORMANT'S NAME (7)			1	9b. MAILING	ADDRESS	(Street a	unkno		ly or Town, State,	Zip Code)	
200 14	an R. Be.	ON	_		8166		_	Drive	Fulton	Maryl		20759
4 🗆 D	urial 2 Crematio	(Specify)		St.	Josep			tery	6/12		nsack,	
	Crey	2>	3.K	<b>1</b>		I	Dona	ldson Fi	uneral 1		_	20707
iMME disea	ART I. Enter the di shock, or hi DIATE CAUSE (Fin se or condition ing in death)	art Milure.	Liet only one cer	caused the cure on each life	10.		the mo	de of dying, au	ch sa cardiac	or respiratory	arrest,	Approximata Interval Betwo Onset and De
CAUS that I	entially list conditi , leading to immed , Enter UNDERLYI E (Disease or injunitiated events ing in death) LAS	diate NG ry	DUE TO	OR AS A CONS	EOUENCE O	F):		212 5	7110	nen's	T4123	700
MEDICAL —	II. Other algnifice		a contributing to					g cause given in		WAS AN AUTOPS PERFORMED? YES 2 NO	6	VERE AUTOPSY FINDI MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
O EX	S CASE REFERRED TO AMINER? YES 2 NO	MEOICAL	HOSPITAL:	FR/Outpetlant	3 □ DOA	OTHER	l:	ACE OF DEATH (C	THE PERSON NAMED IN	-M.3		
27. MAI	NNER OF DEATN	Pending Investigation	28a. OATE OF		20b. TIM		28c. INJ WO	URY AT RESIDENCE PRICE 2 NO		E HOW INJURY	OCCURED	
8 3 4	Suicide 8	Could not ba determined	28e. PLACE ( building	OF INJURY At I , etc. (Specify)	home, farm,	atreet, facto	ory, office		281. LOCATION City or You	(Street and Num rn, State)	nber of Rural Roo	ite Number,
	- 1		CIAN: To the bast of									and manner se state
29b, SI	GNATURE AND TITLE	OF CERTIFIE	R	10				29c. LICENSE NU		29d. [	DATE SIGNED (A	North, Day, Year)
	//											
2 30. NA	ME AND ADDRESS OF		O COMPLETEO CAU		EM 27) (Type	, Print)		CAUR	. 32, 1	20		



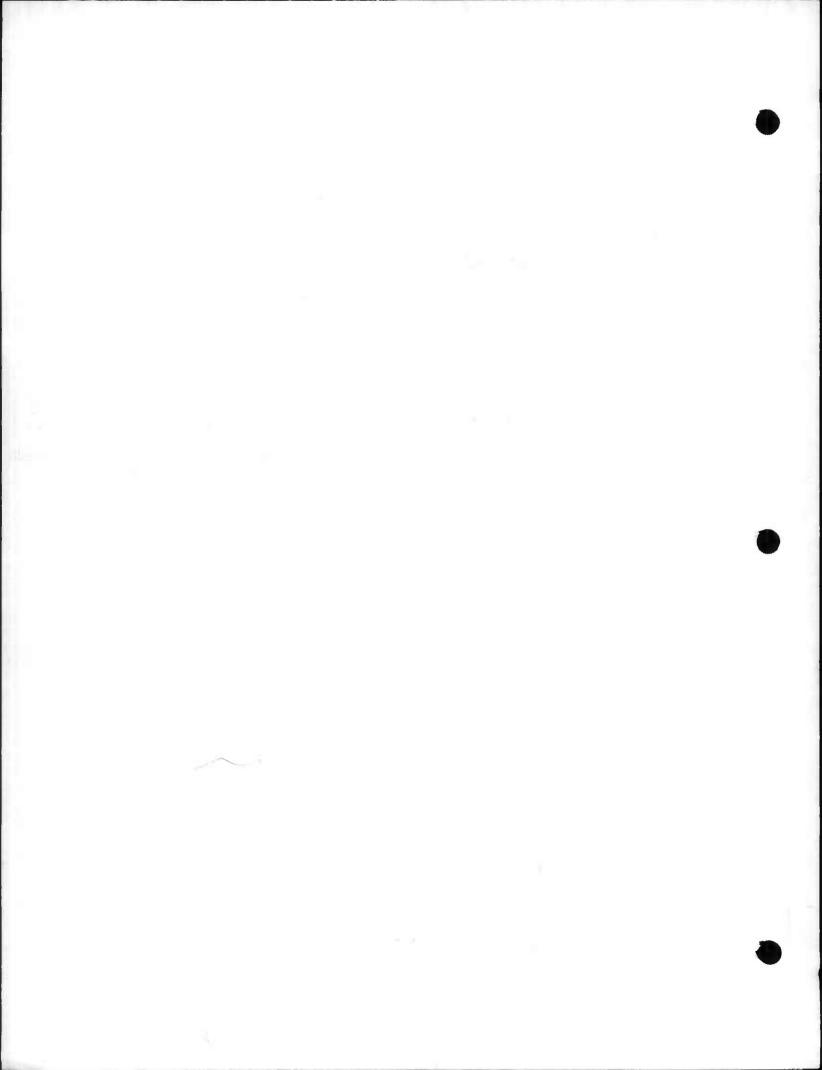
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

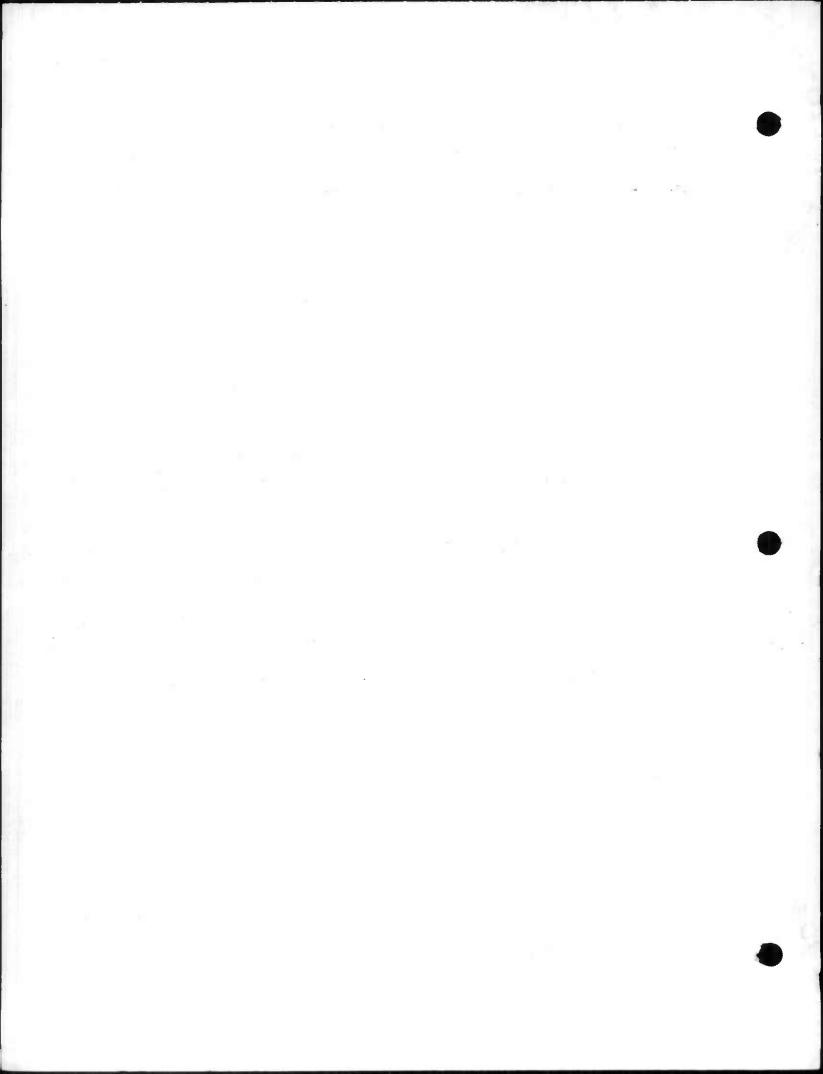
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF ERTIFICATE OF		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
		OGDEN DONELL	AN, JR.		MAY 3	1995	5:15A
	010 01	6. AGE (In yrs. los	YRS. IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Novembe.	1939 8.81	THPLACE (State or Foreign ntry)
	9s. FACILITY NAME (If not institution, give stree	t and number)	9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY OF	ryland DEATH
DIRECTOR	Prince George's	tospital Cent	er Cheu	erly		Prince	beorge's
	Maryland Prin	ce George's	Green k	noith Del+			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	31-B Rido	ae Rd.	1	2077	0	10g. CITIZEN OF	S. A.
FCN	11. MARITAL STATUS	WAS DECEDENT EVER IN U.S. AR		CENDENT OF HISPAI	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No— 14, RA	CE — American Indian,
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Olvorced	IF YES, GIVE WAR OR DATES		S 2 NO Specif			white
	15. DECEDENT'S EDUCAT		CEDENT'S USUAL OCCUPAT	ION	16h KIND OF BU	SINESS/INDUSTRY	witte
ETI	(Specify only highest grade cor	mpleted) (Gi	ive kind of work done during m. Do NOT use retired.)	ost of working		gomery	County
MPL	12		eacher		Publi	i Sc	hools
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0 "		16. MOTHER'S NA	ME (First, Middle, Maider	Surname)	
BE	uggen H	Vonellan	55	11/25	garet	11.	Swett
2	190. INFORMANT'S NAME (Type/Print)	Glocksin 11	b. MAILING ADDRESS (Street	end Number or Rural	Route Number, City or Toy	vn, State, Zip Code)	49442
	20a. METHOD OF DISPOSITION	20h BLACE	AND DATE OF DISPOSITION (A	on age	DATE 20c, LO	CATION - City or	Michigan
	1 Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)		reatory or other place)	Comple	6290 B	randul Ja	Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN		22, NAME A	IND AOORESS OF FA	Clury	1 How	ne 20705
	Matthew 9	+ Brown	Borg	Powde	C Mill	2 Hon Rd Belt	sville mo
	23. PART I. Enter the diseases, or com ahock, or heart failura. Lis	nplicatione that caused the de t only one cause on sech line	ath. Do not enter the m	ode of dying, suc	h ss cardiec or resp	iretory arreat,	Approximats interval Between
	IMMEDIATE CAUSE (Final	() 1- to					Oneat and Death
	disease or condition reaulting in desth)	Per land	y				4-5 day
_		DUE TO (OR AS A CONSEC	DUENCE OF):				4-5 day
ō	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CONSEC	OUENCE OF):				73000
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury	Perilineel	Dialine (2	thete			2 yee
E	that initiated events	DUE TO (OR AS A CONSEC	DUENCE OF):				1 3
CERTIFICATION	resulting in deeth) LAST						
AL O	PART II. Other aignificent conditions of	ontributing to death but not re	equiting in the underlying	ng ceuse given in	Part I. 24s. WAS AN		ib. WERE AUTOPSY FINOINGS
2	Debetes Mellil	is send 86	age Kend	dife	t _ YES		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	Gulfherel Vagu	ilar Difla	er			7	OF DEATH?  1 YES 2 M NO
ž	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF DEA	TH YES 🗆 NO	UNCERTAIN	NX		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	E OF OEATH (Check only one OTHER:	)			
IYSI	1 VES 2 NO 1	Inpatient 2 ER/Outpatient 3	□ DOA 4 □ Nursing Ho	me 5 Residence	6 Other (Specify)		
	1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	INJURY W	JURY AT ORK?	26d. DEŞCRIBE HOW	NJURY OCCURED	
B	2 Accident Investigation 3 Suicide & Could and be	28e. PLACE OF INJURY — At hor			and a occation (o		
COMPLETED	4 Homicide 6 Could not be	building, etc. (Specify)	ms, reim, erreer, ractory, one		28f. LOCATION (Street City or Town, State)	and Number or Hural	Houte Number,
Ë	298. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the beat of my knowledge, dea	eth occurred at the time, dat	a and place, and due	to the several and me		
OME		On the besis of exemination and/or is					(s) and manner as stated.
	290. SIGNATURE AND TITLE OF CERTIFIER	0		29c. LICENSE NUA			D (Month, Day, Year)
38 0	puster se	力也		139	87	15/5	0/98
5	30. NAME AND AODRESS OF PERSON WHO C	OMPLETEO CAUSE OF DEATH (ITEM SIDRIV 7	A 27) (Type, Print)	ware (	uto 0	Icent	self ra
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	Parla II	1		7	
	JUN 08 1995	Tana without To					

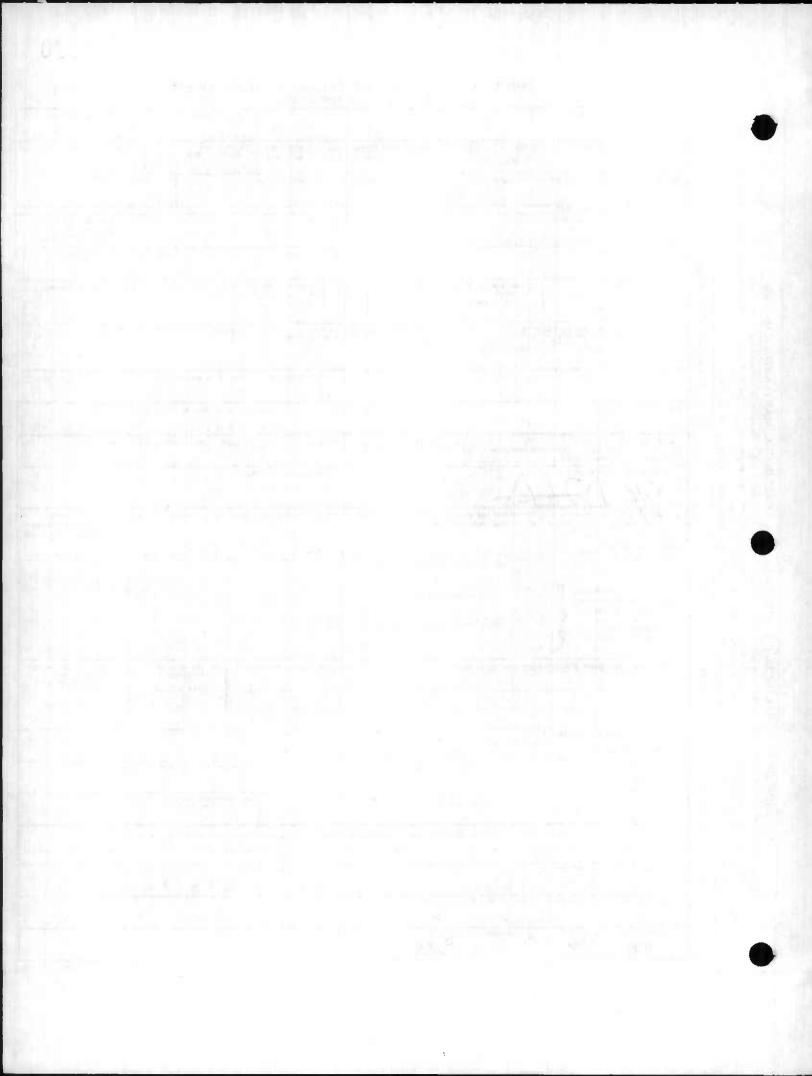


Amended	/	6/5/95, JW, Montgomery Co. 95	18989
1 . STATE		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	

	REGISTRAR		CERTIFIC	CATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)  FRANCES	E.	D'	ANTON	/	2. DATE OF D		10	3.	TIME OF DEA	тн А.,
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(in yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day Sept.	HRTH y, Year)	022	Country)	ACE (State or F	
	9a. FACILITY NAME (If not institution, give		1217				10 1			ington	, DC
OR	Shady Grove Adven				or LOCATION OF DI	EATH			tgome 1		
5	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT								0	7	
DIRECTOR		ontgomery	10c. CITY,	Rockvi						LIMITS?	
FUNERAL	100. STREET AND NUMBER 13407 Parkland	d Drive		101	ZIP CODE	353		10g. CITIZ	ZEN OF WHA	T COUNTRY?	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IF	U.S. ARMED	12 WAS DEC	ENDENT OF HISPAN	NIC OBIGIN3 (B-	nolfy Man	ar No.			
BY	1 Never Married 2 Married 2 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO ATES	if yes, sp	ecify Cuban, Mexica 2 X NO Specifi	in, Puerto Rican	, etc.)	0. 1.0	Black, W Specify:	American Indi Mita, atc. White	wr.,
입	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S U	SUAL OCCUPATION	ON	16b, KINI	D OF BUS	INESS/INDI	USTRY		
Lij.	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	ast of working						
COMPLETED	11 17. FATHER'S NAME (First, Middle, Lest)		Office	Manager					ratory	7	
	Frank Brown				Anna Ma			Surneme)			
8	19a. INFORMANT'S NAME (Type/Print)		105 1101 110	DDDDDD 101111	and Number or Rural	, ,				-	
2	Theresa M. D'Anto	on			nd Drive				2085	53	
	20a. METHOD OF DISPOSITION  1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ioval from State	PLACE AND DATE OF etery, cremetory or other ate of He	FDISPOSITION (Na er place)	me of	5/30			City or Town,		D
	21. SIGNATURE OF PONERAL SERVICE LI		ace of he		O AOORESS OF FA						
	· Hear 41/	y etero			VI Ave. N		_		D.C.		6
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications that caused List only one cause on ea	the death. Do no	t enter the mo	de of dying, auc	h aa cerdiac	or reapir	atory arre	rat,	Approxim	
	IMMEDIATE CAUSE (Finei			-						Onset and	
	disease or condition resulting in death)	· Reape	rator	y ta	elura	2				1100	u
		DUE TO OR AS A	CONSEQUENCE OF	1	elene					1	
CERTIFICATION	Sequentially list conditions,	b. DUF TO (OR AS A	CONSEQUENCE OF	7 -10	fortol	ie				Day	0
AT	if any, laeding to immediate cause. Enter UNDERLYING	9 /								IA-	
프	CAUSE (Disease or injury that initiated events	DUE TO OF AS A	ONSEQUENCE OF):	9						fee	20
듄	resulting in death) LAST	· Atress	File	rella	tim					Dac	300
	PART II Other significant conduct									-	7
EDICAL	PART II. Other eignificent condition						WAS AN A			RE AUTOPSY F	
ğ	0 0 0 0	ellotus, F	prester	es va	seuca	1 1	YES 2	NO		MPLETION OF C	CAUSE
Σ	Violed, Car			rege	Para	_	*		10	YES 2   I	NO
PHYSICIAN:	DID TOBACCO USE CONT			X NO [	UNCERTAIN	<b>И</b> 🗆 📗					
<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)							
ΙΥS	1 YES 2 NO	1   Inpatient 2   ER/Outpi	etient 3 DOA 4	Nursing Hom	e 5 🗌 Residence						
	Natural 5 Pending	(Month, Day, Year)	28b. TIME INJUI	RY WO	URY AT RK? 'ES 2 NO	28d. DESCRIB	E HOW IN	JURY OCC	JREO		
D BY	2 Accident Investigation 2 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, term, str			281. LOCATION	(Street en	d Number (	or Rural Route	Number,	-
ETED	4 Homicide determined	building, etc. (Speci	пу)			City or Tow	vn, Stete)				173
COMPLET	290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my knowle	edge, death occurred	at the time, date	and place, end due	to the cause(e)	end mann	er ee state	d.		
O	one) 2 MEDICAL EXAMINE	R: On the beele of examination	end/or investigation,	In my opinion, de	eath occured at the	time, date and	place, end	due to the	ceuse(s) en	d manner ee s	tated.
Ö	296. SIGNATURE AND TITLE OF CERTIFIE			T	29c. LICENSE NUM	ARFR		20d DATE	SIGNED (Ma	oth One Mont	
0	DRIFTOOK All	ende as			D273	0,		<b>&gt;</b> C	7>/	mil, Dey, real)	
2	30. NAME AND AODRESS OF PERSON WH		ATH (ITEM 27) (Type, P	rint)		_		رح	140	3081	0
	DOUGLAS R. S	How sheet	MO 615	W. MO	DITBOACE	ya	6,1	Roma	NOVE	1000	
	21. DATE FILED (Month, Day, Year) MAY 31 1995	32 REGISTRAR'S SIGNA	TURE							11	



1	REGISTRAR  1. DECEDENT'S NAME (First, Middle,	Last)		OLIVIII I	CATE OF	DEATH	REG.		. 7000
1			0	-			2. DATE OF DEAT MONTH	DAY	YEAR 3. TIME OF
- 8	4. SOCIAL SECURITY NUMBER	5. SEX	C .  8. AGE (In yrs.	Inst hirthdays	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BUT	>( '	. BIRTHPLACE (State
9	226 54 2424	1 M 2 F			MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTI (Month, Day, Yo		Country)
	9a. FACILITY NAME (If not institution,	**	5.5		95 CITY TOWN	OR LOCATION OF O			est Virg
RECTOR	254 N. Washing	No soult referen	#14		Rockv				gomery
띭		OUNTY	77.70	10c, CITY,	, TOWN OR LOCA	ATION			10d. INSIDE
ā	Maryland Mon	ntgomery		Roo	ckville				1 X YES
AL	10e. STREET AND NUMBER					Of. ZIP CODE		10g. CITIZE	N OF WHAT COUNT
FUNER	254 N. Washing	ton Street,	#14			20850		Unite	d States
2	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEOE!	NT EVER IN U.S.			CENOENT OF HISPA pecify Cuban, Mexic			4. RACE — America: Black, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE Y	WAR OR OATES			S 2 NO Speci		7	Specify:
ED	15. OECEOENT'S	Vietn S FOUCATION		OFCEOENT'S I	USUAL OCCUPAT	ION	T see KINO O	F BUSINESS/INDUS	White
ETE	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4 or 5		(Give kind of we life. Do NOT use	rork done during m	lost of working	100. KING O	BUSINESS/INDU	eini
1	Elementary/Secondary (0-12)	5+		Counse	lor		Drug	c Alach	-01
COMPL	17. FATHER'S NAME (First, Middle, Las			Course.		16. MOTHER'S NA	AME (First, Middle, Mi	& Alcoh	C/I
BE C	Homer	Z. Davis				Mary	Margare	t Boble	tt
	19a. INFORMANT'S NAME (Type/Print)	)	-	19b. MAILING	AOORESS (Street	and Number or Rural	Route Number, City o	Town, State, Zip C	(code) 900
5	Christopher Day	vis		936 No	rth San	Vincent	e Blvd.,	#10, Wes	
	20a. METHOD OF DISPOSITION 1 Buriel 2 G Cremetion 3	Barray State	20b. PLAC	CE ANO OATE O	F OISPOSITION /N	iame of	OATE 20	LOCATION CH	ty or Town, State
	4 Donation 5 Other (Specify)		- Mont	tgomery or oth	v Crema	ne 3, 199 torium,	Inic. F	Sethesda	. Marvla
	21. SIGNATURE OF FUNERAL SERVI	CE LICENSES						1 3 5	1 11 11 11
	IMMEDIATE CAUSE (Final disease or condition	s, or complications the	use on eech ii	death. Do no	Avenue ot enter the m		e, Inc. ille, Mar	300 Wes	t Montgo 0850-280 nt, Appr intar
TIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. OUE TO	at caused the suse on each if	death. Do not ine.	Home/i Avenu ot enter the m	Rockville e, Rockv:	e, Inc. ille, Mar	300 Wes	t Montgo 0850-280 nt, Appr intar
AL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. OUE TO  d. OUE TO	at caused the puse on each ii	death. Do not ine.  SEQUENCE OF SEQUENCE OF SEQUENCE OF	Home/i Avenue ot enter the m	Rockville e, Rockvi ode of dying, sur	Part I. 24a, WA	300 Wes	t Montgo 0850-280 nt, Appr intar
MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. OUE TO  d. OUE TO	at caused the puse on each ii	death. Do not ine.  SEQUENCE OF SEQUENCE OF SEQUENCE OF	Home/i Avenue ot enter the m	Rockville e, Rockvi ode of dying, sur	Part I. 24a, WA	300 Wes	t Montgo 0850-280  at, Apprinter Onse
AN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in dasth)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST	b. OUE TO d. ditions contributing to	at caused the puse on each ii	death. Do not ine.  SEQUENCE OF SEQUENCE OF SEQUENCE OF	Home/i Avenue ot enter the m	Rockville e, Rockv: ode of dying, such	Part I. 24a. WAPE	300 Wes	t Montgo 0850-280 nt, Appr Inter Onse  24b. WERE AUTO ANAILABLE; COMPLETIO OF GEATH?
AN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions, if any, seemed and seemed are selected as a series of the cause. Enter Underlying CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. OUE TO  c. OUE TO  d. HOSPITAL:	at caused the ruse on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each ii and on each iii and on each ii and o	death. Do not ine.  SEQUENCE OF SEQUENCE O	Home/i Avenu ot enter the m	ROCKVILLE  e, ROCKVI  ode of dying, sue  The Garage given in	Part I. 24a. WA	300 Wes cyland 2 capiratory arres  S AN AUTOPSY REORMEO? ES 2 M HO	t Montgo 0850-280 nt, Appr Inter Onse  24b. WERE AUTO ANAILABLE; COMPLETIO OF GEATH?
SICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions.  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 NYES 2 NO	b. OUE TO  d. HOSPITAL: 1   Inpetient 2	et caused tha ruse on eech ii a constant of the constant of th	death. Do not ine.  SEQUENCE OF SEQUENCE O	HOME/I Avenu ot enter the m  ii: ii: ii: ii: ii: ii: ii: ii: ii: i	ROCKVILLE  e, ROCKVI  ode of dying, sur  The Garage  ng cause given in  place of OEATH (c)  me \$ Residence	Part I. 24a. Ware to be a cardiac or i	300 Wes cyland 2 capiratory arres  SAN AUTOPSY REORMEO? ES 2 M HO	t Montgo 0850-280 nt, Apprintar Onse  24b. Were Auto AMALABLE I COMPLETIO OF GEATH? 1 YES
AN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions of the condition of the conditions of the	b. OUE TO d. HOSPITAL: 1   Inpetient 2   28a DATE OF (Month, Letter)	at caused the ruse on each if Public on each if	death. Do not ine.  SEQUENCE OF: SEQUENCE OF	HOME/I AVENUE  Other the management of the underlying the underlyi	ROCKVIlle e, ROCKV: ode of dying, sue  The Control one of dying and one of dying, sue  PLACE OF OEATH (C) one of the control on	Part I. 24a. WA PE 1 VI	300 Wes	t Montgo 0850-280  Rt, Appr Inter Onse  24b. WERE AUTO AMAILABLE; COMPLETIO OF GEATH? 1 YES
ED BY PHYSICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in dasth)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions are sufficient conditions.  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 Nes 2 No  27. MANNER OF OEATH  Natural 5 Pending	b. OUE TO  d. OUE TO  d. HOSPITAL: 1   Inpetient : 1   Inpetient : 1   28e DATE Of (Month, Letter)  stion  ot be	at caused the ruse on each if Public on each if	death. Do not ine.  SEQUENCE OF: SEQUENCE OF	HOME/I AVENUE  Other the management of the underlying the underlyi	ROCKVIlle e, ROCKV: ode of dying, sue  The Control one of dying and one of dying, sue  PLACE OF OEATH (C) one of the control on	Part I. 24a. WA PE 1 VI	300 Wes  ryland 2  eapiratory arres  S AN AUTOPSY  RFORMEO?  S 2 M HO  OW INJURY OCCU	t Montgo 0850-280 nt, Apprintar Onse  24b. Were Auto AMALABLE I COMPLETIO OF GEATH? 1 YES
ETED BY PHYSICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions in death) LAST  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 N'ES 2 NO  27. MANNER OF OEATH  Natural 5 Pending Investigs 2 Accident 3 Suicide 6 Could in determine Check only  29a. CERTIFIER 1 CERTIFYING	b. OUE TO  d. OUE TO  d. HOSPITAL: 1   Inpetient : 1   Inpetient : 1   28e DATE Of (Month, Letter)  stion  ot be	at caused the ruse on each ii and the ruse on each ii and the ruse on each ii and the ruse of the ruse	death. Do not ine.  SEQUENCE OF SEQUENCE O	HOME/I Avenue of enter the months in the underlying  28. P OTHER: 4   Nursing Hote E OF   28c. IN JIRY M 1   treet, factory, offile	ROCKV:11ce, ROCKV: ode of dying, such that the control of the cont	Part I. 24a, WAR PE 1 YE 28d. OESCRIBE H 28f. LOCATION (S City or Town, S et o the cause(s) and	300 Wes  Syland 2  Teapiratory arres  S AN AUTOPSY  REFORMEO?  S 2 M HO  OW INJURY OCCU  Inset and Number or  State)	T Montgo 0850-280  III, Apprintar Onse  246. WERE AUTO AMAILABLE I COMPLETIO OF GEATH? 1 YES
BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions are subting in death) LAST  25. WAS CASE REFERRED TO MEDIC EXAMINER?  1 Netural 5 Pending Investigation of the Medicial Process of the Medicial Resulting Investigation of the Medicial Res	b. OUE TO  a. DUE TO  b. OUE TO  d. OUE TO	at caused the suse on each if puse on each if	death. Do not ine.  SEQUENCE OF: SEQUENCE OF: SEQUENCE OF: SEQUENCE OF: A DOA  29b. TIME INJU. Chome, ferm, st. A death occurre- for investigation	HOME/AVENUE AVENUE  Other:  28. P  OTHER: 4   Nursing Hote FOF   28c. IN WRY M 1   III  treet, fectory, offlet d at the time, dat n, in my opinion,	ROCKV:11ce, ROCKV: ode of dying, such that the control of the cont	Part I. 24a. WAPE    Part I. 24a. WAPE   1   Your   Your	300 Wes  yland 2 eapiratory arres  S AN AUTOPSY RFORMEO? ES 2 M HO  OW INJURY OCCU  Insert and Number or State)  If manner as stated as, and due to the	T Montgo 0850-280  III, Apprintar Onse  246. WERE AUTO AMAILABLE I COMPLETIO OF GEATH? 1 YES
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (Fin							DEA			REG. NO.			
		allas H.	D. Hari						2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. Is						June :		95		10:32 PM
230-18-2809		1 🔀 M 2 🗆 F		st birthday) {	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF (Month, D	ley, Yber)		Countr	
\$a. FACILITY NAME (If not			70	1110.	OF CITY	TOur f	D LOCATI		April	21,1			rginia
and the second s			ni+a1		PU. CITY		R LOCATI		AIR			NTY OF D	
RESIDENCE OF DE	CEDENT	CISC HOS	Lai			KO	ckvi	тте			Mo	ntgo	mery
10a. STATE	10b. COUNT	Y		10c. CITY	r, TOWN C	OR LOCAT	ION						10d. INSIDE CITY LIMITS?
		hington				Gl	ade	Spri	ng				1 YES 2 NO
100. STREET AND NUMBER 405 Cresent 11. MARITAL STATUS 1 Never Married 2 K						101	ZIP CODE	E			10g. CITI	IZEN OF V	HAT COUNTRY?
405 Cresent	Drive						2434					ted :	States
t1. MARITAL STATUS	Merried	12. WAS DECEDEN FORCES? 1	X YES 2	RMED NO	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (	Specify Yes	or No-	14. RACE Bleck	- American Indian, White, etc.
3 Wildowed 4 Div	-	IF YES, GIVE W	War II		1	t 🗌 YES	2 X ND	Specify	r.			Speci	White
15. DE	CEDENT'S EDU		16a, Di	ECEDENT'S	USUAL O	CCUPATIO	DN .		16b, Ki	ND OF BUSI	INESS/INC	DUSTRY	MILLE
Elementary/Secondary	nly highest grade (0-12)	College (1-4 or 5 -	H6	live kind of w Do NOT us	vork done e retired.)	during mo	st of workin	g					
12				Pair	nter				5	Self 1	Empl	oved	
Specify or Elementary/Secondary 12  17. FATHER'S NAME (First, I	Middle, Last)						18. MOTH	HER'S NA	ME (First, Midd				
Vance	DeFri	ece							Wheel				
O TOO INFORMANT'S NAME									Route Number,				
Idelile Der								Roc	kville				20850
20a. METHOD OF DISPOSI X Burlai 2 Cremati	on 3 🗆 Ram	oval from Stata	206. PLACE cemetery, cn Park]	AND DATE Commetory or of	F DISPOS her place)	Jun	me of e_6.	199	5 DATE	I		City or To	
4 Donation 5 Other		ENSEF	Park	.awn N	1emo	rial	Parl	k -		Rocl	kvil.	le, N	Maryland
90.		) V_			H.	OME /	Rocks	27 i 1 1 .	Rok	ert A	A. Pu	umphi	cey Funeral
23. PART I. Enter the	10-1	Mill	AS	100348	3 Ro	ockv	ille	, Ma	ryland	208	350-2	2805	ntgomery Ave
IMMEDIATE CAUSE (Fideline and in the condition resulting in death)  Sequentially liet cond if any, leading to immediate. Cause Enter UNDERLY CAUSE (Disease or injust initiated events resulting in death) LAST	tions, ediate ring ring ring ring ring ring ring ring	DUE TO  DUE TO  C. C. C. C. C. C. C. C. C. C. C. C. C. C	death but not	DUENCE OF	): n the un	derlying	r cause g	jiven in	Part I. 24	a. WASAN A PERFORM ☐ YES 2 }	AED?	246.	Onset and Death  Tool 5  Tool
DID TOBACCO U  25. WAS CASE REFERRED  EXAMINER?  1  YES 2  NO		HOSPITAL:	28. PLAI ER/Outpatient 3	E OF DEAT	H (Check o	only one)	5 🗆 Re		6 Other (S	pecify)			
DID TOBACCO L  25. WAS CASE REFERRED  EXAMINER?  1	TO MEDICAL	HOSPITAL:	28. PLAI ER/Outpatient 3 INJURY	E OF DEAT	OTHER 4 Num	only one) R: sing Home 28c. INJI WO	JRY AT	sidenca			JURY OCC	CURED	
DID TOBACCO U  25. WAS CASE REFERRED EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  2		HOSPITAL: 1 Appetient 2 28a. DATE OF (Month, Di	28, PLAGE ER/Outpatient 3 INJURY ny, Year)	DOA 28b, TIME	OTHER 4 Num Num Num M	only one) R: Bing Home 28c. INJI WO 1  Y	JRY AT RK? ES 2	sidenca	6 Other (S) 28d. DESCRI	BE HOW IN			
DID TOBACCO U  25. WAS CASE REFERRED EXAMINER?  1  YES 2  NO  27. MANNER OF DEATH  1  Netural 5  2	TO MEDICAL Pending	HOSPITAL: 1 Supplient 2 28a, DATE OF (Month, Di	28. PLAI ER/Outpatient 3 INJURY	DOA 28b, TIME	OTHER 4 Num Num Num M	only one) R: Bing Home 28c. INJI WO 1  Y	JRY AT RK? ES 2	sidenca	6 Other (S) 28d. DESCRI	BE HOW IN			oute Number,
DID TOBACCO L  25. WAS CASE REFERRED  EXAMINER?  1	Pending investigation Could not be detarmined	HOSPITAL: 1 Suppetient 2 28a. DATE OF (Month, Did 28e. PLACE Of building,	28. PLAI ER/Outpetient 3 INJURY 19, Year) FINJURY — At he etc. (Specify) my knowledge, de	DOA 28b. TIME INJU	OTHEF 4 Num FURY M Irreet, factor	only one) R: sing Home 28c. INJI WO 1  Y ory, office	JRY AT RK? ES 2 and place,	NO NO and dua	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R	DN (Street an own, State)	od Number	or Rural R	oute <i>Number</i> , and manner as stated.
DID TOBACCO U  25. WAS CASE REFERRED  EXAMINER?  1	Pending Investigation Could not be detarmined TIFYING PHYSIC DICAL EXAMINE	HOSPITAL: 1 Supported 2 28a, DATE OF (Month, Did 28e, PLACE Of building,  CIAN: To the best of R: On the basis of ex-	28. PLAI ER/Outpetient 3 INJURY 19, Year) FINJURY — At he etc. (Specify) my knowledge, de	DOA 28b. TIME INJU	OTHEF 4 Num FURY M Irreet, factor	only one) R: sing Home 28c. INJI WO 1  Y ory, office	JRY AT RK? ES 2 and place,	NO NO and dua	6 Other (S) 28d. DESCRI 28f. LOCATIC City or Ti to the cause(tilme, date and	DN (Street an own, State)	od Number ner sa state dua to th	or Rural R	
DID TOBACCO U  25. WAS CASE REFERRED  EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Natural 5	Pending investigation Could not be detarmined TIFYING PHYSIC DICAL EXAMINE	HOSPITAL: 1 SUnpetient 2 28a. DATE OF (Month, Did 28a. PLACE Of building, 28a. PLACE Of building, CIAN: To the best of ex	28. PLAI ER/Outpetient 3 INJURY ny, 'bear') F INJURY — At he atc. (Specify) my knowledge, di amination and/or	DE OF DEAT	OTHEF 4 Num E OF JRY M treet, factor d at the ti	only one) R: sing Home 28c. INJI WO 1  Y ory, office	JRY AT RK? ES 2 and place, path occurs	NO NO and dua	6 Other (S) 28d. DESCRI 28f. LOCATIC City or Ti to the cause(tilme, date and	DN (Street an own, State)	od Number ner sa state dua to th	or Rural R	and manner as stated. (Month, Day, Year)
DID TOBACCO L  25. WAS CASE REFERRED  EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5  2  Accident  3  Suicide 6   4 Homicide  29a. CERTIFIER (Check only one) 2  MED  29b. SIGNATURE AND TITL  30. NAME AND ADDRESS O	Pending investigation Could not be detarmined TIFYING PHYSIC DICAL EXAMINE	HOSPITAL: 1 SUnpetient 2 28a. DATE OF (Month, Did 28a. PLACE Of building, 28a. PLACE Of building, CIAN: To the best of ex	28. PLAM ER/Outpatient 3 INJURY y, Year) F INJURY — At he etc. (Specify) my knowledge, de amination and/or	DE OF DEATH DOA  28b. TIME No. Time, farm, si  28b. Time farm, si  28b. Time No. Time farm, si  28b. Time No. T	H (Check of OTHER 4   Number of Survey M   Number of Survey M   Number of Survey M   Number of Survey of S	only one) R: sing Hom 28c. INJI WO 1 V ory, office	and place, with occurrence of the country of the co	and dua and at the NSE NUM	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R to the cause(i	DN (Street and Street and Street and Street and Street and Street)	od Number	or Rural R ed. e cause(s)	and manner as stated. (Month, Day, Year)
DID TOBACCO L  25. WAS CASE REFERRED  EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5   2  Accident  3  Suicide 6   4  Homicide  29a. CERTIFIER (Check only one) 2  MED  29b. SIGNATURE AND TITL  30. NAME AND ADDRESS OF THE COMMENT OF THE CERTIFIER (Check only one) 2  MED  30. NAME AND ADDRESS OF THE CERTIFIER AND TITL  30. NAME AND THE CERTIFIER AND TITL  30. NAME AND THE CERTIFIER AND TITL  30. NAME AN	Pending investigation Could not be determined TTIFYING PHYSII DICAL EXAMINE F PERSON WHO	HOSPITAL: 1 SUnpetient 2 28a. DATE OF (Month, D) 28a. PLACE Of building, CIAN: To the best of R: On the basis of ex	28. PLAI ER/Outpetlent 3 INJURY y, Year) F INJURY — At he etc. (Specify) my knowledge, de amination and/or	DE OF DEAT DOA DOA DOA DOA DOA DOA DOA DOA DOA DOA	H (Check of OTHER 4   Number of Survey M   Number of Survey M   Number of Survey M   Number of Survey of S	only one) R: sing Hom 28c. INJI WO 1 V ory, office	and place, with occurrence of the country of the co	and dua and at the NSE NUM	6 Other (S) 28d. DESCRI 28f. LOCATIC City or Ti to the cause(tilme, date and	DN (Street and Street and Street and Street and Street and Street)	od Number	or Rural R ed. e cause(s)	and manner as stated. (Month, Day, Year)
DID TOBACCO L  25. WAS CASE REFERRED  EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5  2  Accident  3  Suicide 6   4 Homicide  29a. CERTIFIER (Check only one) 2  MED  29b. SIGNATURE AND TITL  30. NAME AND ADDRESS O	Pending investigation Could not be determined TTIFYING PHYSII DICAL EXAMINE F PERSON WHO	HOSPITAL: 1 SUppetient 2 26a. DATE OF (Month, D.) 26a. PLACE Of building, CIAN: To the best of R: On the basis of ex	28. PLAM ER/Outpatient 3 INJURY y, Year) F INJURY — At he etc. (Specify) my knowledge, de amination and/or	DE OF DEATH DOA  28b. TIME Some, farm, st  Death occurre- Investigation M 27) (Type,	H (Check of OTHER 4   Number of Survey M   Number of Survey M   Number of Survey M   Number of Survey of S	only one) R: sing Hom 28c. INJI WO 1 V ory, office	and place, with occurrence of the country of the co	and dua and at the NSE NUM	6 Other (S) 28d. DESCRI 28f. LOCATIC City or R to the cause(i	DN (Street and Street and Street and Street and Street and Street)	od Number	or Rural R ed. e cause(s)	and manner as stated. (Month, Day, Year)

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	1 - STATE REGISTRAR	STATE OF MA				HEALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)		- OL	him	CATE	F DEALH	REG. NO	).	1.1	IME OF DEATH
							MONTH C		YEAR	
	Vernon Dui 4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	hirthday)	IF UNDER 1 YEA	IF UNDER 24 HRS.	May 27, 1	995		:55AM M
1	577-38-8455	1 ☑ M 2 ☐ F	73	YRS.	MONTHS DAY		(Month, Day, Year)		Country)	E (State or Foreign
	9a. FACILITY NAME (If not institution, give at		7.5	20.23	AN CITY TON	/N OR LOCATION OF DE	January 29		2 Lot	isiana
<u>۳</u>	Perry Point VA H			- 1		Point	-3171			
18	RESIDENCE OF DECEDENT				rerry	FOIIIL		Cec	il Co	unty
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY	, TOWN OR LO	CATION			10d.	INSIDE CITY LIMITS?
	Virginia Fair	fax		For	t Belv	oir			1 [	YES 2 NO
₹ I	10e, STREET AND NUMBER					101. ZIP CODE		10g. CITIZE	N OF WHAT	COUNTRY?
FUNERAL	P.O. Box 1368					22060		USA		
5	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT ET			13. WAS	DECENDENT OF HISPAN , specify Cuban, Mexica	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	or No — 14	RACE - A	merican Indian,
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES			YES 2 NO Specify			Specify:	
0	15. DECEDENT'S EDUC		16a, DEC	EDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	SINESS (IND.)	Cauca	islan
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(G/vi		rork done during	most of working	United			ernment
.   필	12	2	Pho	otog	rapher		Departm			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NAI	ME (First, Middle, Maiden			
BE (	George Durapau					Una Vai	ughan			
10 B	19a, INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Stre	et and Number or Rural F	Route Number, City or Tox	n, State, Zip Co	ode)	
-	Kathleen Devereau	ıx	P	.0.	Box 13	68, Fort	Belvoir, V	irgini	la 22	060
	20e. METHOD OF DISPOSITION 1	eval from State	20b. PLACE AN	ND DATE O	F DISPOSITION	(Name of	DATE 20c. LC	CATION — CI	y or Town, S	tata
	4 Donation 6 Other (Specify)		Arling	gton	Nation	nal Cemete	ry 6/5 Ar1	ington	, Vir	ginia
	2. SIGNATURE OF EUNERAL SERVICE LIC	ENGEE ()			Den Den	AND ADDRESS OF FAC	ral Homes,	Inc.		
	10.	DUL					Virginia			
	23. PART I. Enter the diseases, or c	omplications that ca	used the deal	th. Do n					it,	Approximate
	ahock, or heert failure. I IMMEDIATE CAUSE (Final	lat only one ceuse	on each line.							Interval Between Onset and Death
	disease or condition reaulting in death)	Congesti	ve Hear	t Fa	ilure	severe			į	
		DUE TO (OR	AS A CONSEQU	JENCE OF	):					
2	Sequentially list conditions,	Arterios				sease				
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	,	AS A CONSEQU		):					
I I	CAUSE (Disease or injury	Post Pa	AS A CONSEGU		١.					
CERTIFICATION	that initiated events reaulting in deeth) LAST	50E 10 (0h	AS A CONSEGU	PENCE OF	<b>j</b> .					
E E										
A.	PART ii. Other algnificent conditions	contributing to dec	eth but not res	suiting in	n the underly	ring cause given in	Part I. 24a, WAS AN			AUTOPSY FINDINGS
음	Diabetes MI	Ellitus					1   YES 2		COM	ABLE PRIOR TO PLETION OF CAUSE EATH?
WE										YES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	IBUTE TO CAUS	E OF DEAT	H YE	S NO	☐ UNCERTAIN	1 🗆			
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE		H (Check only o	ne)				
YSI	1 TES 2 NO	1X Inpatient 2 - ER	/Outpatient 3		OTHER:	ome 5 - Residence	6 Other (Specify)			
HA	27. MANNER OF DEATH 1 ☑ telephone 5 ☐ Pending	28a. DATE OF INJ (Month, Day, Y		28b. TIME	OF 28c.	INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUP	RED	
BY	2 Accident Investigation					YES 2 NO				
8	3 Suicida 8 Could not be 4 Homicide determined	28s. PLACE OF IN building, stc.	JURY — At home (Specify)	e, farm, st	treat, tactory, o	ffice	281. LOCATION (Street ( City or Town, State)	and Number or	Rural Route I	lumber,
1	AND DESCRIPTION									
MPL	(Check only									
COMPLETE	2 MEDICAL EXAMINER	: On the basis of exemi	nation and/or inv	restigation	, in my opinior	i, death occured at the t	time, data and place, en	d due to the c	evee(s) and	manner as stated.
BE	296 S GNATURE AND TITLE OF CERTIFIER	[ /		10		29c. LICENSE NUM	BER	29d. DATE S	IGNED (Mont	h, Day, Year)
5	THENCH A.	Janto	1	20		151094-	1	1	27	4/1
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM:	27) (Type,	Print)					

PERRY POINT.

Jalia Dhudhar Rarball

MD

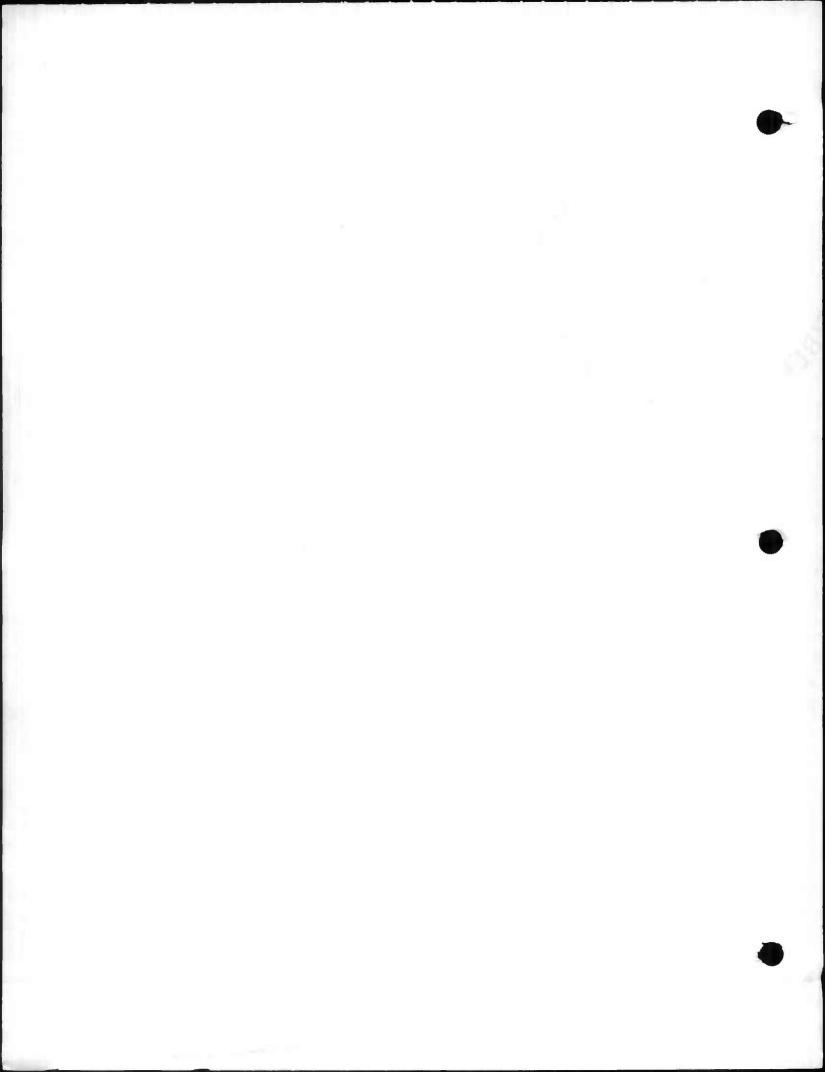
21902

SANTPOS M 1. Day: Year) N 05 1995

MELECTA

31. DATE FILED (Month)

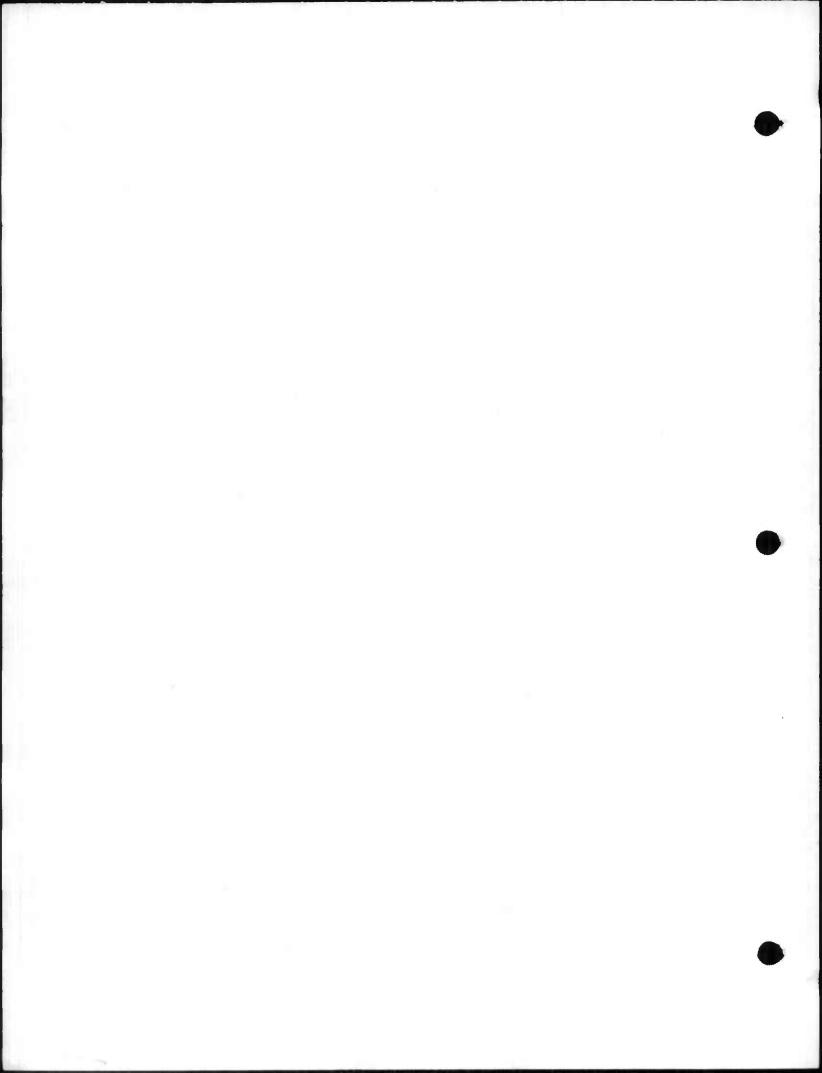
JUN



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	REGISTRAR			=R	CALE	OF	DEAT	H	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)  Louise A.	Delaney	,					1	2. DATE OF June	DEATH DA	1995	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t hirthdey)	IF UNDER 1	VEAR	IF UNDER 2	24 1400	7. DATE OF				IPLACE (State or Foreign
	215-34-3028	1 🗌 M 2 💢 F	73	YRS.		DAYS	HOURS	MIN.	JUTY	6,1	921	Ma	ryland
	Se. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	TOWN C	OR LOCATIO	N OF DE	ATH		9c. COU	NTY OF D	EATH
DIRECTOR	Holy Cross Hos	pital			Silv	ver	Spr	ing			Mo	ontg	omery
5	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY			10c CITY	TOWN OF	BLOCAT	TON						
E		gomery			akor		Par	k					10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	gomery			G11-01		ZIP CODE	-	-		10a CITI	ZEN OF Y	1 ☑ YES 2 ☐ NO WHAT COUNTRY?
FUNERAL	7620 Maple Ave	, Apt #	429				2091	2				S A	
5	11. MARITAL STATUS	12. WAS DECEDENT		MED	13. W	AS DEC	ENDENT OF	NISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian, t, White, etc.
ВУ Е	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W		Ю			ecify Cuben. 2 🔀 NO		n, Puerto Rica:	n, etc.)		Speci	fy:
	15. DECEDENT'S EDUC	ATION	se- pr	OFFICE IN	1								ack
COMPLETED	(Specify only highest grade     Elementery/Secondary (0-12)	completed)	(G/	CEDENT'S I we kind of w Do NOT use	ork done di		st of working	7	16b, KIN	ID OF BUS	INESS/INC	DUSTRY	
PL	7th Grade	College (1-4 or 5+		omes	tic				412	No	ne		
S S	17. FATHER'S NAME (First, Middle, Last)								ME (First, Midd				
BE C	Walter Delan	ey					A	nni	e Dod	lson			
TO E	190. INFORMANT'S NAME (Type/Print)  Mrs Catherine	(Sister		MAILING	AODRESS	(Street a	nd Number o	or Aural A	loute Number, (	Olty or Town	n, Statu, Zip	Code)	- Deals M
		Reduix						,	Apt #				a Park, Mo
	26e, METNOD OF DISPOSITION 1	val from State	ASh M					277	6/8		- MOITAS		ing, Md
÷	21 SIGNATURE OF FUNERAL SERVICE LICE	NEE /	Mail M	iemo1	22. N	AME AN	D ADDRESS	S OF FAC	YLITY				
4	minus t	H		ř									. 20850
-	23. PART I. Enter the diseases, or co	omplications that	Coursed the de-	eth Do o									kville, Mo
	snock, or neart failure. L	ls) only one caus	se on each line.		or anten t	THE THO	de or dyni	ig, such	aa cardiac	or respii	ratory arr	est,	Approximata interval Between
	IMMEDIATE CAUSE (Finsi disesse or condition	er	OTIC	0	450	-1-							Onset and Death
	reaulting in death)	OUE TO	PTIC	UENCE OF	<i>[[]()</i> ()	UK							2 days
Z	Commentation that are all to the book of t	OBSTRI	UCTEL	DV	EN	TR	AL	1+	ERNI	A			3 days
F		OUE TO	OR AS A CONSEC	UENCE OF	:								
	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO	OR AS A CONSEQ	LIENCE OF									
CERTIFICATION	that initisted events resulting in death) LAST		(off No A Golfge	IOLINOL OF	,								1
	2122 11 201 1 11												
EDICAL	PART II. Other significant conditions	contributing to	daath but not re	eaulting in	tha und	lerlying	cause gi	ven in i	Part I. 24s	PERFOR		246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	DIABETES	1							10	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
	AZOTEMI		UCE OF BEAT	FLL VE			1 111100						1 TYES 2 NO
AN	DID TOBACCO USE CONTR	IBUIE IO CAI		E OF DEATH			UNCE	KIAIN					
PHYSICIAN: M	EXAMINER?	HOSPITAL:			OTHER:		. s 🗆 e	ldama d	■ Other (Sp				
¥	27. MANNER OF DEATN	28e. DATE OF	INJURY	28b. TIME	OF 2	28c. INJI	URY AT	idence :	28d. DESCRIE		JURY OCC	CURED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ly, fear)	INJU	M	1 🗌 Y	RK? 'ES 2	NO					
	3 Suicide 8 Could not ba	28e. PLACE Of building.	F INJURY — At horetc. (Specify)	ne, farm, at	reet, factor	ry, office			28f. LOCATIO	N (Street a	nd Number	or Rural R	loute Number,
COMPLETED	4 Homicide determined								Ony or 10	wri, Giata)			
립	29e. CERTIFIER (Check only one)												
Š	2 MEDICAL EXAMINER	On the basis of ex	amination end/or is	nvestigation	, In my opi	Inion, de	eth occured	d at the t	ime, date end	place, end	due to th	e cause(s)	end manner es stated.
BE (	296. SIGNATURE AND TITLE OF CERTIFIER		1. 1-1	40			29c. LICEN		10				(Month, Day, Year)
0	10mil. Ken	neve	rough	n).				200	002		▶J(	INE	2 1995
	30. NAME AND ADDRESS OF PERSON WHO	PLAT M	OF OEATH (ITEM	- 1	Print) H	st,	C		2 - 00			0	4.00.0
	31. DATE FILED (Month, Day, Year)	32, REGISTRAF	R'S SIGNATURE	01 /	6 3	>1,	3/2	VER	RSPR.	1100	MA	KYL	AND 20910
	JUN 16 1995		velsor Rand	all									
	311 4 1330	1											- 1



BALTIMORE, MARYLAND 21215-0020	TZ4 hours after death. Page 6 may be retained by the hospital or attending physician.	tely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE,	urs after death. Page 6 may be	in by the funeral director, page
	nit 24 ho	tely filled in by the

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		ll.
TO BE COMP	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
he funeral director, page 5 should be detached ral.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	
ar death. Page 6 may be retained by the hospit	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	/

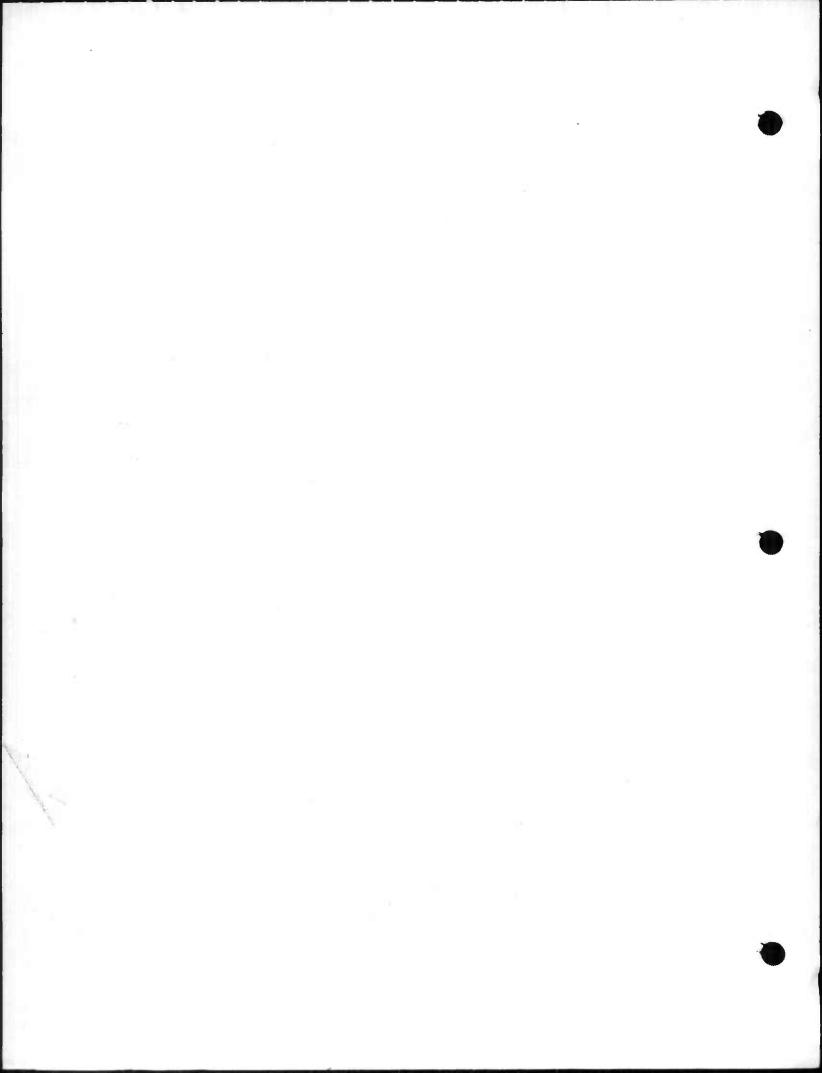
	1 - STATE OF MARYLAI REGISTRAR	ND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN			
	ECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATN							3. TIME OF DEATH
		AUIS			PT		9 95	3:55 AM
		yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Consumbasi	LACE (State or Foreign
	220-42-4308 1	YRS.				L944	Mar	yland
œ		المبائمة		R LOCATION OF D	EATH		NTY OF DE	ATH
DIRECTOR	Howard County General Hos	prtar	COIU	mbia		HOV	ward	
RE	10a. STATE 10b. COUNTY	INC. CITY, TOWN OR EDGATION						10d, INSIDE CITY
	Maryland Howard		Columbi					1 X YES 2 NO
10e. STREET AND NUMBER  9518 Many Mile Mews  10f. ZIP CODE  10g. CITIZEN OF WY  21046  U.S.A  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Tes 22060  13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14. RACE Black.  14. RACE Black.								
¥	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	SARMED	12 WAS DEC	21046	NIC ORIGIN? (Specify Yes		S.A	
7	1 Never Married 2 Married FORCES? 1 YES	2X 100	It yes, spi	cify Cuban, Mexica 2 X NO Specif	in, Puerto Rican, atc.)	or No-	Black, Specify	- American Indian, White, etc.
ЭВУ	3 Widowed 4 Divorced			Z QZ IIO Opecii	y			ack
COMPLETED	(Specify only highest grade completed)	(Give kind of v	USUAL OCCUPATION WORK done during most	IN st of working	16b. KIND OF BU	SINESS/IND	USTRY	
7	Elementary/Secondary (0-12)  College (1-4 or 5+)  6 YYS	Teach			Dall C	12 1	Deels 1	1 - 0 - 1 - 1 -
NO.	17. FATNER'S NAME (First, Middle, Lest)	Teaci	ier	18. MOTHER'S NA	ME (First, Middle, Maiden		Pub.	lic Schls
BE C	Donald E. Johnson				eva S.		in	
10 B	19e. INFORMANT'S NAME (Type/Print) (Husband)				Route Number, City or Tow			
-	Mr Lanneau H. Davis Jr.	9518	Many	Mile Me	ews, Colu	ımbia	a, Mo	1 21046
	1 € Burial 2 □ Cremation 3 □ Removal from State □ camete	on cometon of of	F DISPOSITION (Na her place)			CATION —		
	4 Donation 5 Other (Specify) Ma	ryland		ans Cer	0.6/12 Cr	owns	svil.	Le, Md
	the parage A	1	Snow	den Fur	neral Hom			
$\dashv$	23. PART I. Enter the diseases, or complications that csused the	be death Do o	246	N. Wash	nington S	t, F	Rocky	ville, Md
	shock, or heart fallure. List only one cause on esci	h line.	or enter the mo	ae or dying, suc	ii ss cardisc or respi	ratory sr	est,	Approximate interval Between
	disease or condition resulting in death)  s	stue	Carlin	in was the	1			Onset and Death
				7-11-11	<del>J</del>			
Z	Sequentially list conditions.	s Me	Hotes					
AT	If any, leading to immediate		pe fa	1				
FIG	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CO	ONSEQUENCE OF	PIL fa	11013				-
CERTIFICATION	resulting in desth) LAST							
	PART II. Other significant conditions contributing to death but	not resulting is	n the underlying	Cause alven in	Part I, 24a, WAS AN	ALITOROV	1 645 1	
PHYSICIAN: MEDICAL	2101210	not resulting in	in the underlying	Cause given in	PERFOR	MED?		VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
					1 TYES 2	900	9	OF DEATH?
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YE	S   NO	UNCERTAIN	<u>-</u>		'	YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26.	PLACE OF DEAT	N (Check only one)					
YSI	1 YES 2 NO 1 Inpetient 2 ER/Outpatie			5 - Residence	6 Other (Specify)			
	27. MANNER OF DEATH  288. DATE OF INJURY (Month, Dey, Yeer)	26b. TIME	JRY WO	RK?	28d. DESCRIBE HOW I	NJURY OCC	CURED	
à	2 Accident Investigation 3 Suicide 8 Could not be 28s. PLACE OF INJURY —	At home, farm, at		ES 2 NO	28f. LOCATION (Street a	and Months	a. 0/ 0	
COMPLETED	4 Nomicide 6 Could not be determined building, etc. (Specify)		reactive, other		City or Town, State)	ing Number	or nunii not	ne Number,
LE LE	29a. CERTIFIER Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge.	ge, death occurre	d at the time, date	and place, and due	In the cause(s) and man	nor so state		
No.	one) 2 MEDICAL EXAMINER: On the basis of examination at							and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER		T	29c. LICENSE NUN				fonth, Day, Yber)
TO BE	& Cant lane	m		7212	62	D J	we -	7,1995
-	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH							
	31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATU	POAD	Suite	EID	Columbia	4,19	210	44
	31. DATE FILED (Month, Day, Year)  JUN 09 1995  JUN 09 1995  JUN 09 1995	LIL						
	JUN 00 1333							

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FENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	3 should		
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ate be en	hysician a	prior to	or framme
ath certific	ttending p	tal Hygiene	or othe
hat the de	d by the a	and Men	and in land
requires t	een signe	of Health	shows a
V: The law	cate has b	th the State Dept. of Health and Mental Hygiene prior to builal, cremation, or removal.	d or flem 23 shows any injury or other traumatic event the medical examinar must be notified at one.
PHYSICIA	this certifi	with the	
TENDING	TOR; After	ofter death	28 is ma
O THE HOSPITAL OR ATTENDING PHYSIC	AL DIREC	be filed within 72 hours after death v	MPORTANT: If Hem 28 is mark
HE HOSPI	HE FUNER	ed within	DRITANT
10	T0 T	De fil	MP

95 18995 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATN Rose A. Durso

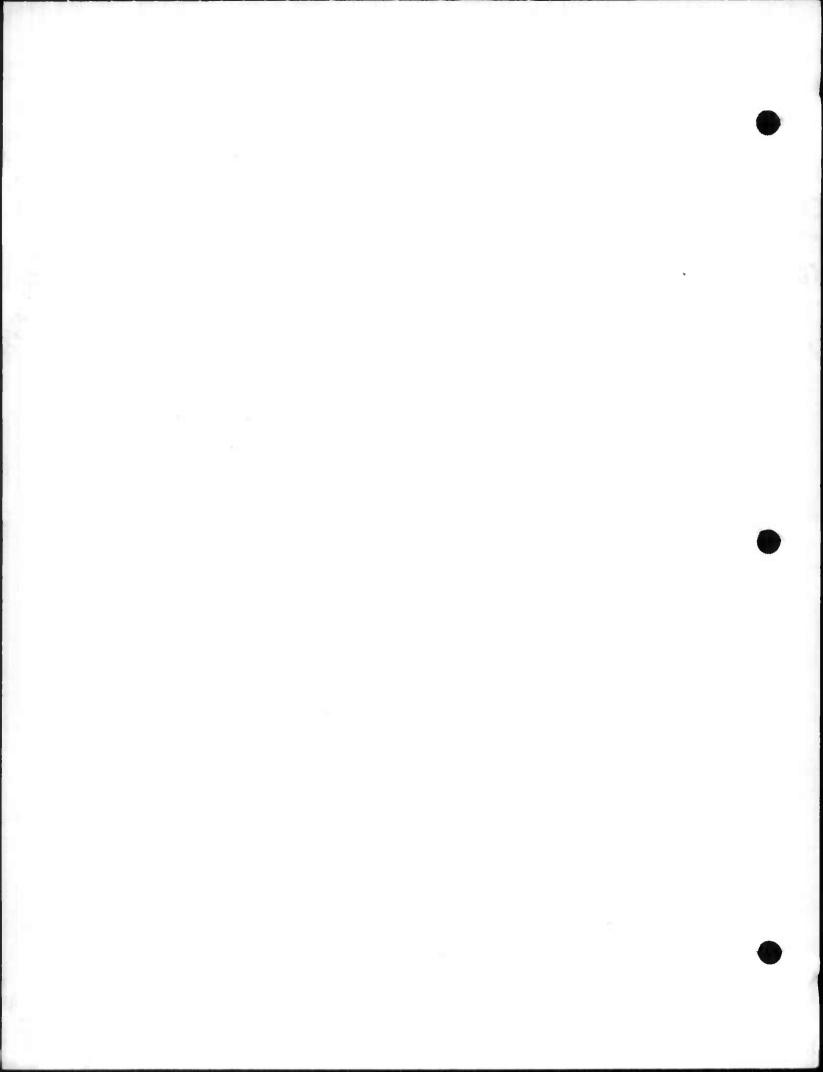
	Rose A. Durso				_				June 6,	1995	)	_	8:45 A	M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIR	TN	8.1	BIRTNPLA	CE (State or Foreign	_
	579-58-7740	70 FO 77 O I M 2 D F O MONTHS DAYS HOURS MIN. (Month, Day, Year) Country)							Country)					
	9a. FACILITY NAME (If not institution, give a	- A	0.5										ngton, D.C	
~					96. CITY	TOWN	R LOCATIO	N OF DE	ATH	9c.	COUNTY	OF DEAT	N	
DIRECTOR	Kensington Garden	s Nursing	Home		K	ensi	ngtor	1			Mon	tgom	ery	
ŭ	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN C	R LOCAT	ION					104	. INSIDE CITY	-
	Maryland M	(on to our our			011								LIMITS?	
		lontgomery			SILVE		pring					1 [	YES 2 NO	
₹	10e. STREET AND NUMBER					101.	ZIP CODE			10g.	. CITIZEN	OF WHAT	COUNTRY?	
FUNERAL	11709 Kemp Mill R	load					2090	12			TT	C A		
5	11. MARITAL STATUS	12. WAS DECEDENT E	EVER IN U.S. ARI	MED	13.1	MAS DEC			IC ORIGIN? (Spec	Man as No		S.A.		_
	1 Never Married 2 Married	FORCES? 1	YES 2 N		13.	f yes, spe	elfy Cuban	, Maxicar	n, Puerto Ricen, a	ity tee or No	)— 14.	Black, W	American Indian, hite, etc.	
À	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES		1 1	☐ YES	2 X NO	Specify	7			Specify:		
											1	Whit	e	
u	15. DECEDENT'S EDU (Specify only highest grade				USUAL O		N st of working		16b. KIND	OF BUSINESS	S/INDUST	RY		
<u>.</u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)	runny mos	st or working	'						
Z	12	The state of the s	Ho	memal	kor				0	- II				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		110	memai	VET			-		n Home				_
_							16. MOTN	ER'S NAI	ME (First, Middle, I	Meiden Surner	me)			П
N N	Anthony J. Ferro						Mar	y Gi	ualtiera	a				
5	19a. INFORMANT'S NAME (Type/Print)		19b	. MAILING	ADDRESS	(Street a	nd Number o	or Rural R	loute Number, City	or Town, State	e, Zip Cod	fo)		
-	Michael A. Durso												1 00000	
İ	20a. METNOD OF DISPOSITION							ad					nd 20902	
	1 Buriel 2 Cremetion 3 Rem	oval from Stata	20b. PLACE A cemetery, crer	natory or of	ther place)					Oc. LOCATION	N — City	or Town,	State	
1	4 Donation 5 Other (Specify)	1	Metro	poli	tan (	Crem	atory	6/	9/95	Alexar	ndria	a.Vi	rginia	
ł	21. SIGNATURE OF PUNERAL SERVICE LIN	CENSEE //					D ADDRESS		CILITY					
	· KIT	(11/	- 47		Fı	anc	is J.	Co	llins Fu	ineral	L Hor	me,	Inc.	
	1 ) obers 1	an	rele	1	50	00 U1	niver	sity	v Blvd.	.W. Si	11. S1	pr	MD 20901	
	23. PART I. Enter the diseases, or	complications that co	oused the def	nth. Do n	ot enter	the mo	de of dyln	g, auch	aa cerdisc or	respiratory	y arrest.		Approximats	$\neg$
- 1	anock, or neart isliure.	List only one cause	on each line.					-					Interval Between	
Н	IMMEDIATE CAUSE (Fins)								Onset and Dsati	h				
	resulting in death)							1 Year						
- 14	DUE TO (OR AS A CONSEQUENCE OF):									_				
- 11														
.												i		
20	Sequentially list conditions,	b	R AS A CONSEO	UENCE OF										
ALION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	R AS A CONSEO	UENCE OF	7):									-
FICALION	if sny, isading to immedists cause. Enter UNDERLYING CAUSE (Disease or injury	b. OUE TO (OF												
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	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. OUE TO (OF DUE TO (OF	R AS A CONSEO	UENCE OF	j:									
	If any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. OUE TO (OF DUE TO (OF	R AS A CONSEO	UENCE OF	j:	derlying	Ceuse gl	ven in i	Part I. 24s. W	AS AN AUTOF			RE AUTOPSY FINDINGS ILABLE PRIOR TO	
JICAL CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. OUE TO (OF DUE TO (OF	R AS A CONSEO	UENCE OF	j:	derlying	ceuse gl	ven in I	P	ERFORMED?		AMA CON	ILABLE PRIOR TO IPLETION OF CAUSE	
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. OUE TO (OF DUE TO (OF	R AS A CONSEO	UENCE OF	j:	derlying	ceuse gl	ven in I	P			COI OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition	b. OUE TO (OF DUE TO (OF d	R AS A CONSEC	UENCE OF	n the un				1 1	ERFORMED?		COI OF	ILABLE PRIOR TO IPLETION OF CAUSE	
	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI	b. OUE TO (OF DUE TO (OF d	R AS A CONSECUTION OF THE PROPERTY OF DEAT	DENCE OF	n the un	10 🗆			1 1	ERFORMED?		COI OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
AN: MEDICAL	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI	b. OUE TO (OF DUE TO (OF d	R AS A CONSEC	DENCE OF	n the un	10 🗆	UNCE	RTAIN	1 D 1	ERFORMED?		COI OF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
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SICIAN: MEDICAL	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATN  1   Natural   5   Pending Investigation	b. OUE TO (OF C. DUE TO (OF d. DUE TO CAUSE CONTRIBUTE TO CAUSE HOSPITAL:  1   Inpetient 2   Ef	SE OF DEAL 26. PLACE R/Outperlant 3 JURY Wear)	DOA TIME	S N (Check of OTHER 4 & Number of Unity M	nity one) i: ing Home 26c. INJL WOF	UNCE	RTAIN	8 Other (Specific 28d. DESCRIBE)	ERFORMED?  TES 2 2 No.	OCCURE	AVA CON OF	ILABLE PRIOR TO WPLETION OF CAUSE DEATH? ] YES 2   NO	
D DI PRISICIAN: MEDICAL	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	b. OUE TO (OF c. DUE TO (OF d	SE OF DEAT  26. PLACE R/Outpetlant 3 JURY Year)  NJURY — At hon	DOA TIME	S N (Check of OTHER 4 & Number of Unity M	nity one) i: ing Home 26c. INJL WOF	UNCE	RTAIN	B Other (Specific Spe	PERFORMED?  YES 2 2 NO  YES 1 NO  YES 2 NO  YE	OCCURE	AVA CON OF	ILABLE PRIOR TO WPLETION OF CAUSE DEATH? ] YES 2   NO	
ED BY PRISICIAN: MEDICAL	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation	b. OUE TO (OF c. DUE TO (OF d	SE OF DEAT  26. PLACE R/Outpetlant 3 JURY Year)  NJURY — At hon	DOA TIME	S N (Check of OTHER 4 & Number of Unity M	nity one) i: ing Home 26c. INJL WOF	UNCE	RTAIN	8 Other (Specific 28d. DESCRIBE)	PERFORMED?  YES 2 2 NO  YES 1 NO  YES 2 NO  YE	OCCURE	AVA CON OF	ILABLE PRIOR TO WPLETION OF CAUSE DEATH? ] YES 2   NO	
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ETED BY PHISICIAN: MEDICAL	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  2. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINE	DUE TO (OF  C. DUE TO (OF  d	SE OF DEAT  26. PLACE R/Outpetient 3 JURY Year) NJURY — At hon (Specify)	DOA 26b. TIME	n the unit of the thick of the	ing Home 28c. INJL WOF 1 Y  Y  The pry, office	UNCE  5 Resi	RTAIN  Idence (	B Other (Specification of Specification	YES 2 25 NC  YES 2 25 NC  YES 2 26 NC  YES 2 26 NC	OCCURE  Moor or R.  stated.  to the cas	AMA CON CON OF 1 1 ED  ED  ED  GRAPH	ILABLE PRIOR TO MOPLETION OF CAUSE DEATH?  YES 2 NO  Number, I manner as stated.	
E COMPLETED BY PRISICIAN: MEDICAL	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	b. OUE TO (OF c. DUE TO (OF d	SE OF DEAT  26. PLACI  27. PLACI  28. PLACI  28. PLACI  28. PLACI  29. PLACI  29. PLACI  20. PLACI	Described in the course of the	n the unit (Check of CHER)  A 69 Num  E OF URY  M  Add at the the	ing Home 28c. INJL WOF 1 Y  Y  The pry, office	UNCE  5 Residence  15 Residence  15 Residence  16 Residenc	RTAIN  Idence (	B Other (Specification of Specification	YES 2 25 NC  YES 2 25 NC  YES 2 26 NC  YES 2 26 NC	OCCURE  Moor or R.  stated.  to the cas	AMA CON CON OF 1 1 ED  ED  ED  GRAPH	ILABLE PRIOR TO WPLETION OF CAUSE DEATH?  YES 2 NO  Number,	
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E COMPLETED BY PRISICIAN: MEDICAL	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 YES 2 NO  27. MANNER OF DEATN  1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be datermined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29e. SIGNATURE AND TITLE OF CERTIFIER  (Check only one) 30. NAME AND ADDRESS OF PERSON WN	DUE TO (OF  C. DUE TO (OF  d. DUE TO (OF  d. BE CONTRIBUTE TO CAUSE  HOSPITAL: 1 Inputant 2 Es. DATE OF IN	SE OF DEAT  28. PLACE  R/Outpetlant 3  JURY  Year)  NURY — At hon.  (Specify)  knowledge, dea  Wation and/or in	DOA 28b. TIME INJ.  th occurre ivestigation 27) (Type,	The unit of the un	inty one) i: ing Home 28c. INJL WOF 1  Y  Tory, office	UNCE  5 G Resilier  Rey AT  18K?  ES 2 G  and place, a  ath occurace  29c. LICEN	RTAIN  Idence (	B Other (Special Speci	YES 2 2 NO  NO  NO  NO  NO  NO  NO  NO  NO  NO	occurse  most or Ri  stated.  to the cau  DATE SIG	AMA COR OF OF OF OF OF OF OF OF OF OF OF OF OF	Number,  I manner as stated.  11995	
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r com terteb bi rilisician, medical	If sny, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTI  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 YES 2 NO  27. MANNER OF DEATN  1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be datermined  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29e. SIGNATURE AND TITLE OF CERTIFIER  (Check only one) 30. NAME AND ADDRESS OF PERSON WN	DUE TO (OF  C. DUE TO (OF  d. DUE TO (OF  d. BE CONTRIBUTE TO CAUSE  HOSPITAL: 1 Inputant 2 Es. DATE OF IN	SE OF DEAT  28. PLACE  R/Outpetlant 3  JURY  Year)  NURY — At hon.  (Specify)  knowledge, dea  Wation and/or in	DOA 28b. TIME INJ.  th occurre ivestigation 27) (Type,	The unit of the un	inty one) i: ing Home 28c. INJL WOF 1  Y  Tory, office	UNCE  5 G Resilier  Rey AT  18K?  ES 2 G  and place, a  ath occurace  29c. LICEN	RTAIN  Idence (	B Other (Special Speci	YES 2 2 NO  NO  NO  NO  NO  NO  NO  NO  NO  NO	occurse  most or Ri  stated.  to the cau  DATE SIG	AMA COR OF OF OF OF OF OF OF OF OF OF OF OF OF	ILABLE PRIOR TO MOPLETION OF CAUSE DEATH?  YES 2 NO  Number, I manner as stated.	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within critical hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or named	IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA CERTIFIC	MENT OF H	EALTH AND DEATH		YGIENE EG. NO.		
		. SEX 6. AGE (In	yrs. last birthday)	UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF I	DEATH DAY	3. TIME OF DEATH 15 1 30 P  8. BIRTHPLACE (State or Foreign Country)	
TOR	Se. FACILITY NAME (If not institution, give street	t and number)	PITTAL 91	Cha	R LOCATION OF D	Dec. 17, 1918 Washington,  DEATH  DEA			
- DIRECTOR	Maryland Cal	lvert	10c. CITY, T	10c. CITY, TOWN OR LOCATION Owings				10d. INSIDE CITY LIMITS? 1 YES 2X NO	
FUNERAL	475 W. Chesapeake	10.40450		20736			U.S.A.		
B	1 Never Merried 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	ENDENT OF NISPA city Cuban, Maxic 2 NO Speci	en, Puerto Ricar	pecify Yea or No— i, etc.)	14. RACE — American Indian, Black, Whita, atc. Specify: White	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION npleted) Cotlege (1-4 or 6+)	(Give kind of work life. Do NOT use re	done during mo tired.)	it of working		O OF BUSINESS/INC	DUSTRY	
OM	17. FATNER'S NAME (First, Middle, Lest)	11ebs becretary rederal gove						ernment	
	Joseph H. Dougl					Anderso:			
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILINO AD	DRESS (Street a			ity or Town, State, Zig			
2	Jean W. Douglas								
	Jean W. Douglas  475 W. Chesapeake Beach Rd. Owings, Md. 20736  20c. METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of Completery, Cremetory or other place)  Resurrection Cemetery  475 W. Chesapeake Beach Rd. Owings, Md. 20736  20c. LOCATION - City or Town, State  Completery, Cremetory or other place)  Resurrection Cemetery  475 W. Chesapeake Beach Rd. Owings, Md. 20736  20c. LOCATION - City or Town, State  Completery, Cremetory or other place)  Clinton, Maryland								
	21. SIGNATURE OF TUNERAL SERVICE LIGERS	Halas		Geor	ge P. Ka	las Fu	neral Ho		
CERTIFICATION	23. PART I. Enter the seese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or shock, or beart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):						or reapiratory an	Approximate interval Batwe Onset and Day	
PHYSICIAN: MEDICAL C	ADENOCAP	- co	COLON 1 YE			WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAI	иПГ			
Sic	EXAMINER?	OSPITAL:	0	THER:					
Η̈́	27. MANNER OF DEATN	26s. DATE OF INJURY	28b. TIME O	F 28c. INJI	5 Residence		IE HOW INJURY OC	CURED	
	1 Natural 5 Pending	(Month, Day, Year)	INJURY		ES 2 NO				
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined	26s. PLACE OF INJURY — building, etc. (Specify	- At home, farm, stree	t, factory, office		261. LOCATION	N (Street and Number wn, State)	or Rurel Route Number,	
281. LOCATION (Street and Number or Rid LOCATION (Street and Number or Rid City or Town, State)  293. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as steted.									
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER		-m		D-18	S4S	29d. DAT	E SIGNED (Month, Day, Year) UNE 6, 1995	
	30. NAME AND ADMINISTRATION WHO CO	OMPLETED CAUSE OF DEAT	88 Ox	N HIL	L RI	PAD	Dxov H	U MANJANI	
	JUN 08 Julia Starvidge Ray 1 11								



**BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

James Edward

Davis

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an object of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	ATE OF MARYLAND /	DEPARTM	MENT OF HE	ALTH ANI DEATH	D MEI	NTAL HYGIEN	E		
2000		ames Edward	Davis	, III		2.	DATE OF DEATH 6.	11-9	5 43 3.	1952 M
	212 90 0032 11	M 2 □ F 28	YRS. MO		IF UNDER 24 HRS	Ap	Month, Day, Year)		Country)	ington, DC
TOR	9e. FACILITY NAME (# not institution, give street and Union Hospital of ( RESIDENCE OF DECEMENT		91	Elkton		DEATH		ec. COUNTY OF DEATH Cecil		
DIRECTOR	Maryland Cecil			own or location	ON				d. INSIDE CITY LIMITS?  YES 2 NO	
FUNERAL	232 East High Stree			101.	21921				S.A.	T COUNTRY?
8	1 Never Married 2 X Married FO	AS OECEDENT EVER IN U.S. AR PRCES? 1 TYES 2 TYPE YES, GIVE WAR OR DATES	MED NO	If yes, spec		ricen, Pu	RIGIN? (Specify Yea arto Rican, stc.)	or No-	14. RACE — Black, Wi Specify:	American Indian, hita, atc. White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12)  1.2	ge (1-4 or 5+) (Gi	CEDENT'S USI five kind of work Do NOT use no	UAL OCCUPATION done during most stired.)	of working		Restau		JSTRY	
BE COM	17. FATNER'S NAME (First, Middle, Last)  James E. Dav		OOK		18. MOTNER'S		First, Middle, Meiden :	Surname)		
10	19a. INFORMANT'S NAME (Type/Print)  Marie S. Davis		232 Ea	st High	Stree	ral Route	Number, City or Town	E1kto	n, MD	
	20s. METNOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	m State 20b. PLACE A complexy, cre Elkt	metory or other On Cen	V		1	994 E1	kton,	Mary	
	Donard &	Hickory		103 E1kt	West S	toc	r Funera kton Str 1921-552	eet 1		
	23. PART I. Enter the diseases, or compile ahock, or heart failure. List on IMMEDIATE CAUSE (Finel disease or condition resulting in death)	cartions that caused the de-			n of dylng, s	uch aa	cardiac or reapir	ratory arre	eat,	Approximata interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CONSEC	DUENCE OF):							
CERTIF	that initiated avents resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):							
AL	PART II. Other algnificent conditions contr	ibuting to death but not re	esulting in t	he underlying	cause given	in Part	i. 24a. WAS AN / PERFORI 1 YES 2	MED?	AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTION 25. WAS CASE REFERRED TO MEDICAL		TH YES		UNCERTA	AIN [			1	YES 2 NO
Sic		PITAL: patient 2 - ER/Outpatient 3		THER: Nursing Nome	5 - Residence	:e 6 🗆	Other (Specify)		-	
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	Ba, DATE OF INJURY (Month, Day, Year)	26b. TIME OF	M 1 YE		26d.	DESCRIBE HOW IN	JURY OCCL	JRED	
ETED	4 Homicide determined	Be. PLACE OF INJURY — At her building, atc. (Specify)					LOCATION (Street ar City or Town, Stete)			Number,
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the	the best of my knowledge, des e beals of exemination end/or i	eth occurred si	the time, date at	nd place, and d	he time,	cause(a) and mann data and place, and	ner ea stated	d. cause(a) and	d manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIES  30. NAME AND ADDRESS OF PERSON WHO COMPI	ushow S San			D23	322		≥ 6/	SIGNED (MO)	nth, Day, Year)
	S.S. Sachdev, M.D.	- 118 North 8	Street		on, MD	21	.921			
	JUN 1 3 1995	Talia Studien Ra	Lett							

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## DIVISION OF VITAL RECORDS, P.O. BOX 68760,

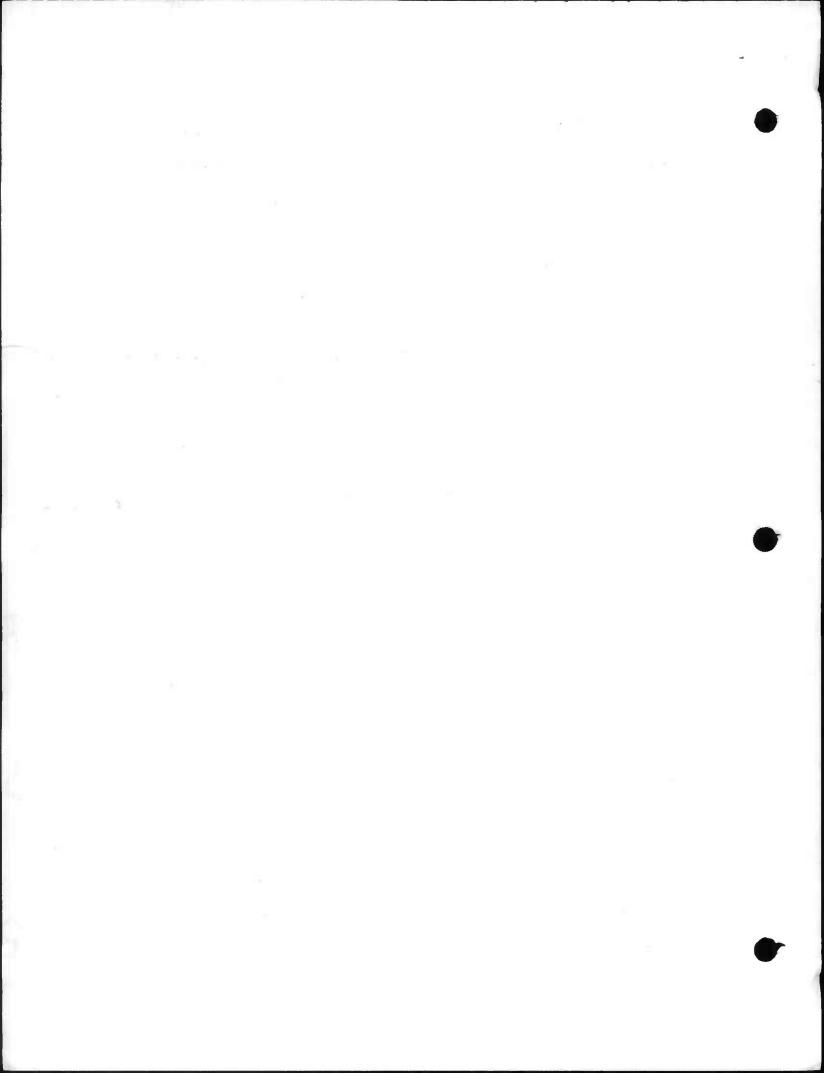
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a five death. Page 6 may be retained by the hospital or attending physician.

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STATE OF	MARYLAND / DEPARTMENT	OF HEALTH AN	D MENTAL	HYGIENE
	CERTIFICATE	OF DEATH		REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND	MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH	V VEAD	3. TIME OF DEATN	
- 1	John Alvin	Davis			June 13,	1995	8:30 PM	
į		5. SEX 6. AGE (In		UNDER 1 YEAR IF UNDER 24 HRS. ITHE DAYS HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) Feb 6, 19	Coun	HPLACE (State or Foreign try)	
E I	98. FACILITY NAME (If not institution, give street Carroll County	CITY, TOWN OR LOCATION OF DE Westminster	EATN	9c. COUNTY OF	DEATN			
5	RESIDENCE OF DECEDENT		·					
DIRECTOR	9	roll	oll Finksburg					
FUNERAL	828 Wesley Road			101. ZIP CODE 21048			WHAT COUNTRY? USA	
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	13. WAS DECENDENT OF NISPAI	n, Puerto Rican, etc.)	Blec	E — American Indian, ck, White, etc.	
ED BY	3 Widowed 4 Divorced  15. DECEDENT'S EDUCA		8s. DECEDENT'S USU	1 TYES 2 XNO Specif	16b. KIND OF BUS	Spec	White	
COMPLETE	(Specify only highest grade co	conpleted) College (1-4 or 5+)	(Give kind of work life. Do NOT use ret Constru	done during most of working ired.)	100 100 100	Mille	·	
N N	17. FATHER'S NAME (First, Middle, Last)		CONSCIC		ME (First, Middle, Malden			
BE C	Franklin Alvin	Davis			Eavey	sumsme)		
10	190. INFORMANT'S NAME (Type/Print) Roberta Lee Dav	is		esley Rd, Fi			48	
	20e. METHOD OF DISPOSITION  1  Burlsi 2 Cremation 3 Remove  4  Donation 5 Other (Specify)		LACE AND DATE OF DI	sposition (Name of		cation — city or t		
	21. SIGNATURE OF SUMERAL SERVICE LICE			22. NAME AND ADDRESS OF FA			al Home	
	It wer	V. Elia	e	934 S Main	St, Hamp	stead,		
	23. PART I. Enter the diseases, or con shock, or haart fellure. List	mplications thet ceused t st only one cause on acc	he death. Do not e h lina.	enter the mode of dying, suc	h ea cardiec or respi	ratory arreat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	A	( GW2	ventricu Cor	E.b. (Cot	con :	Onset and Death	
	resulting in death) a.	DUE TO (OR AS A C	ONSEQUENCE OF				VICE TOOL PAGE	
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF):					
	cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	DUE TO (OR AS A C	ONSEQUENCE OF):					
CERT	resulting in death) LAST							
AL	PART II. Other algnificent conditions	contributing to deeth but	not resulting in th	e underlying cause given in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDIC				,	1 🗆 YES 2	Жио	OF DEATH?  1 YES 2 NO	
N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	NO UNCERTAI	X			
		HOSPITAL:  Inpetient 2 ER/Outpet		HER:				
Ë	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME OF	Nursing Homa 5 Residence 28c. INJURY AT	28d. DESCRIBE HOW II	NJURY OCCURED		
2	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	УЯЛСИ	M 1 YES 2 NO			100	
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, etc. (Specify	At home, ferm, stree	t, factory, office	28f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,	
ן ב	29s. CERTIFIER (Check only	AN: To the best of my knowled	ge, death occurred at	the time, data and place, and due	to the cause(s) and man	ner es stated.		
COMPLETED				my opinion, death occured et the			s) and manner as stated.	
BE	29b. SIGNATURE AND TENE CERTIFIER	W0		29c LICENSE NUI	MBER OS	29d. DATE SIGNED	Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT		10:	en betead	me 3	1071	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE	eson hines . I	no Parette		3.1	
	JUN 1 4 1995 Juli	d'hucker Rade	1				22-1-0	



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95 18999 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Mary Edythe Eicke June 7, 1995 6:25 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 579-28-1960 1 M 2 X F 70 May 14,1925 California 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 11113 Whisperwood Lane Rockville Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary1and Montgomery Rockville 1 YES 2 X NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11113 Whisperwood Lane 20852 United States 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married BY 3 Widowed 4 Divorced Specify: White 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only h (Give kind of work done during m life. Do NOT use retired.) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) Frank Imrev Helen Walsh 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) Woodward G Eicke 11113 Whisperwood Lane, Rockville, Maryland 20852 1995 DATE 20a. METHOD OF DISPOSITION
1X Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other place) June 10, Parklawn Memorial Park 20c. LOCATION - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) \_ Rockville, Maryland 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 21. SIGNATURE OF FUNERAL SERVICE LICENSEE XUI M00348 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Acute Myelogenous Leukemia 6 months resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Myelo Dysplastic Syndrome 6 months PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Multiple Myeloma 6 vears CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 1 NO OF DEATH? 1 - YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 2 UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 XNO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED XXNatural 8 Pending Investigation BY t ☐ YES 2 ☐ NO 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) COMPLETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide 29a. CERTIFIER

\*\*Chart only

\*\*CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 3 MEDICAL EXAMINER: On the bests pland/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D09577

10400 Connecticut Ave., Kensington, Maryland



2

and 6

Richard H. Pollen,

JUN 09 1995

31. DATE FILED (Month, Day, Year)

oll

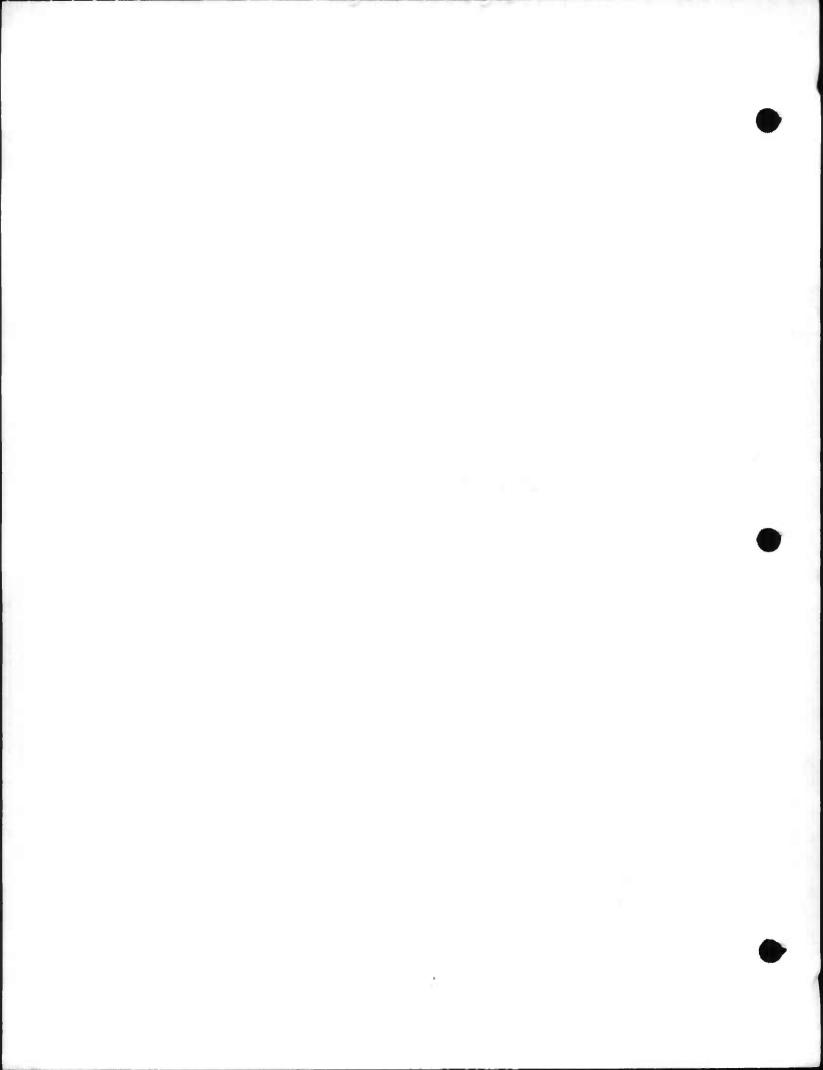
M.D.,

32. REGISTRAR'S SIGNATURE

MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

June 8, 1995

20895



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME								3. TIME OF DEATH	
	CHARL	ES DAVID EPI	LING			JUNE 6		EAR P	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.			T DATE OF BIRTH				
	215-72-1928	1 🔀 M 2 🗌 F	36 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Feb. 7, 1	959 M	country) laryland	
	9a. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN	OR LOCATION OF O		9c. COUNTY		
OR	NATIONAL NAVAL MEDICAL CENTER			BE	THESDA		MON	TGOMERY	
اق	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY			, TOWN OR LOCA			HOWTOOMBRE		
DIRECTOR					TION			10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER				, ZIP CODE			1 X YES 2 NO	
BA	404 Carroll Avenu	10		1	20707			OF WHAT COUNTRY?	
FUNERAL		12. WAS DECEDENT EVER IP	IIIS ARMEO			NIC ORIGIN? (Specify Yes	U.S.A	RACE — American Indian,	
	1 📉 Never Married 2 🗌 Married	FORCES? 1 X YES	2 NO	If yes, sp	ecify Cuban, Maxica	in, Puarto Rican, etc.)	OF 140   14.	Black, White, atc.	
B	3 Wildowed 4 Divorced	" TES, GIVE WAR ON DI	4129	T TES	2 X NO Specif	<b>y</b> :		Specify: Italian	
COMPLETED	15. OECEDENT'S EDUCAT (Specify only highest grade co	TION ampleted)	18a. DECEDENT'S	USUAL OCCUPATION done during me	ON	16b. KIND OF BU	SINESS/INDUS	TRY	
	Elementary/Secondary (0-12)	College (t-4 or 5+)	life. Do NOT us	e retired.)	ist or working				
₽ Z	12		Navy			United	States	Government	
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	,		
H	Charles Ronnie Ep	ling				la Carmela			
2			1			Route Number, City or Tow			
	Phyllis J. Cipria					ce, Laurel			
	1 N Burial 2 Cremation 3 Remove	al from Stata	PLACEAND DATE Of etery, crematory or of	has alana)		1		or Town, Slate	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE AI	A	22. NAME A	NO ADDRESS OF FA	CILITY		on, Virginia	
	· Charles	r 1200	()	Franc	ls Gasch	s Sons Fur	neral H	Home, P.A.	
	1			4739 I	<u>Baltimore</u>	Ave., Hya	attsvi]	lle, MD 20781	
	23. PART I. Entar the diseases, or cor shock, or heart failure. Lis	mplications that cause on a	l the death. Do n ach lina.	ot antar tha mo	da of dying, auc	h aa cardiac or reapi	iratory arrest	Approximata interval Between	
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death	
			MOMEDIASTINUM O (OR AS A CONSEQUENCE OF):						
_	_								
CERTIFICATION	Sequentially list conditions, if any, laeding to immediate	ACQUIRED OUE TO (OR AS A	CONSEQUENCE OF	EFICLENC	Y SYNDRO	)ME			
SAT	cause. Enter UNDERLYING							İ	
<u>E</u>	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	):					
E	resulting in death) LAST								
	PART II. Other algnificant conditions	contributing to death b	ut not reaulting is	the underlyin	cause given in	Part I. 24s. WAS AN	AUTOBEV	24b. WERE AUTOPSY FINDINGS	
CAL		- 87			g casse given ai	PERFOR	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC						t X YES 2	□ NO	OF DEATH?	
Α.	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	E DEATH VE	S D NO D	LINCEDTAI			t 🗆 YES 2 🛣 NO	
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		UNCERIAII	ч 🗆			
Sic		IOSPITAL:	atlant 3 🗆 DOA	OTHER:	5 🗆 Beeldenee	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED	
ВУР	t 🕅 Natural 5 🗌 Pending 2 🗍 Accident Investigation	(Month, Day, Year)	INJU		PRK?				
ED B	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, st	treet, lactory, offic		281. LOCATION (Street	and Number or F	Rural Route Number,	
	4 Homicide determined	January, and Jopes	"))			City or Town, State)			
1 2	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the beat of my knowl	edga, death occurre	d at the time, date	and place, and due	to the cause(a) and mar	mer as stated.		
COMPLET								ruse(a) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	4			29c. LICENSE NUI		1119111111	GNED (Month, Day, Year)	
) BE	John E.K	Ser MO						7/95	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	D-4271 NATIONA	L NAVAL ME			
	J.E.BROWN, LCDR	, MC, USNR			BETHESD		9-5600		
	31. OATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA				2000	, , , , , , , , , , , , , , , , , , , ,		
	JUN 08 mar July	Davidson Rand	all						

